NOTES ON IDENTIFICATION IN A CASE OF DEPRESSION REACTIVE TO THE DEATH OF A LOVE OBJECT

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In his paper, Mourning and Melancholia, published in 1917, Freud set forth a psychodynamic interpretation of melancholia on the basis of studies made in a few manic-depressive cases. There was no attempt at wide generalization or claim to universal validity. He agreed that many depressions suggesting a physiological etiology did not come under his consideration of psychogenesis. Further psychoanalytic research by him and others has confirmed and widened the application of the first tentative hypothesis. The chief features of this now familiar formulation are as follows: melancholic depression does not occur without psychopathological predisposition. This predisposition comprises libido fixation at anal levels with a resulting structure similar to that in severe obsessional states although overt manifestations may be lacking. In addition there is included a still deeper and special oral organization which is specific to the pathology of the depressive reaction and differentiates it from the lesser neuroses. The ambivalence to love objects characteristic of pregenital levels is extreme in the depressive temperament and is readily activated under new provocation which threatens loss. This special sensitiveness has an etiological connection with failure to achieve in childhood the usual libidinal separation from parents, especially the mother. The individual has never relinquished the early parental love objects and while he has made a fair-weather surface adjustment, there is preserved in his unconscious an unstable neurotic compromise in place of a real adjustment to the original disappointment and loss. The emancipation procedure failed of solution and acted instead as a trauma which left an unhealed wound ready to break out afresh at any repetition of injury.

Precipitating causes for later depressive attacks include recognizable deprivations in real life or concealed equivalents in the unconscious. The experience most obvious to an observer is the loss by death of a loved person who has assumed the rôle of the original object and therefore toward whom libidinal investment is especially tenacious. Even for a normal adult the sudden deprivation experienced at the death of a loved one is traumatic in the extreme. The period of acute grief and mourning covers the slow withdrawal and redistribution of the libido under compulsion of the reality principle. The subject of a true depression is unable to make this adjustment and often enough falls back to the procedure by which he avoided his original loss, namely, regression to the earlier libidinal stages and retention of the object by incorporation. This regressive appropriation accomplished, so to speak, by force and seizure still further strengthens the hostile component of the ambivalent relationship.

States of melancholia and of mourning have much in common. Freud emphasized one outstanding difference between them, which is, the reduction of self-esteem and the self-condemnation so striking in depression and absent in ordinary grief. Certain puzzling features of the melancholic's self-depreciation have long been noted. He does not act as though altogether overcome with self-reproach or shame and there is insistence and aggression in his self-depreciation. He intrudes on those around him with his complaints and is far removed from the attitudes of humiliation and submission appropriate to his self-condemnation. Furthermore, he may seem to gain some perverse pleasure from his tirades and there is not lacking a sense of self-importance. By and large there is much that is more familiar to the expression of a grievance against others than in a sense of unworthiness of the self. The confirmation of this latter conjecture, says Freud, gives the clue to the clinical picture. The reproaches of the melancholic are not primarily against himself but against an object which has been shifted to his own ego. In the psychic drama of the unconscious there has been accomplished the purpose of holding fast

to the object, but at the expense of finding an enemy in camp instead of a friend.

The notes here presented are from the analysis of a man of forty years with a marked obsessional character and neurotic behavior but without previous depressive attacks. The opportunity for study was unusual, as the analysis began after depression had set in as a reaction to the incurable illness of his wife and extended over a period which included her death. Systematic analysis in the early part was interfered with by the need for frequent supportive psychotherapy and broken off by force of circumstances after ten months. No great change appeared to be accomplished in modification of the patient's fundamental neurotic problems, but it was possible, on the basis of the productions brought out under analytic procedure, to see clearly what was occurring to complicate a reaction of grief to bereavement. Happily also there was sufficient clinical improvement to enable the patient to carry on throughout the period without the breakdown threatened in the beginning. The neurotic naïveté of this man was extraordinary, and in striking contrast to his education and intelligence and to his officially conventional personality. The characteristic isolation and displacement mechanisms of the obsessional character were outstanding and permitted undisguised expression of the unconscious in dream, fantasy and symptomatic act, clear enough to the observer, but excluded from any type of insight on the part of the subject. A single example of these mechanisms will suffice. The patient had the agreeable habit of paying his monthly bill the day after its receipt. On one occasion he entered the analyst's office with a check in his hand and, as he extended it, stated with evidence of strong feeling that he wished some advice with reference to the bill of a surgeon who had attended his wife. He felt that he had been overcharged, took the attitude that something should be done and implied an obligation for assistance from the analyst. It is true that he was under unusual medical expense, but at the time the analysis represented the major outlay and there had

been already plenty of evidence to show his strong protest over the financial arrangement. He was aware of no connection between his resentment at the surgeon's quite reasonable charges and his attitude to the analyst. An attempt to point out some parallel was unsuccessful and he remained convinced that the matter was pure coincidence.

The essential facts of the patient's history are as follows. He came from a middle class family at a marginal economic level. The father was of high intelligence, but untrained, egocentric and visionary. The mother was of the *Hausfrau* type, much older than her husband, and wholly out of sympathy with him. Many years of quarreling and unhappiness ended with divorce in the patient's late teens. The mother made the son her confidant; in his adolescence she told him of her sexual frigidity and distaste and referred to his own conception as the result of her being 'overcome' by his father who had been openly unfaithful, boasted of his conquests and brought other women into the home. There was one sister two years older, a plodding and dutiful type. In the home the father was an autocrat, demanding special consideration from the wife and military obedience from the children. There was much physical punishment of the boy for peccadilloes. When he was twelve years old the father noisily accused him of masturbation, punished him severely, and threatened to shame him before the mother and sister. During his teens as a result of the parents' estrangement the boy and father slept together. He believes that while he appeared asleep the father once felt of his genitals for the purpose, he assumed, of ascertaining if there was an erection. This incident as so many others was dissociated from conscious affect; he mentioned it casually and neither then nor later ascribed importance to it. During this time he often masturbated after his father left the bed in the morning and smeared semen on the wall without conscious purpose but apparently in part as an act of defiance. Similar defilement took place in college days when he expressed his anger with a landlady by secret expectorations into her window draperies. After adolescence there was a striking poverty of

affect of any kind towards the father, and in the analysis it was not possible to bring to life the real relationship which inferentially was profoundly ambivalent and inclined in the direction both of hostility and of a passive feminine attitude.

That his relationship to women was on a mother-sister pattern was revealed much more clearly. He was a mother's boy type, protected and indulged at home and shielded from outside contacts. Inconsistencies in the maternal attitude brought rebellion on his part, and the positive relationship was much more evident toward the placid and unselfish sister. In childhood the two were companions and felt little need for other playmates. Due to unevenness of intellectual capacity they were classmates at primary school. In the eighth grade the sister failed, was forced to repeat, and the brother with high marks faced what to him was a painful separation. He became physically ill and was out of school for a year under medical care for what was said to be an affection of the heart. Later findings did not bear out the original diagnosis of an important organic lesion and in retrospect it seemed clear enough that this episode was psychogenic. He said to the analyst, with reference to his sister's failure, 'It did not seem that I could go on alone', exactly the words he used later in regard to the approaching death of his wife. On the basis of this supposed heart illness he gave up all athletic activities and decided to prepare for a scholar's life rather than take a more active place in the world of business and affairs. The latter road meant to him being like his father and stood for full masculinity. Much analytic material showed that behind this decision was a deeper choice which included a partial feminine identification. In his chosen field of study he was successful in a pedantic fashion and while later circumstances brought him back into the business field, he retained scholarly interests and associations. In connection with some work in college he developed a sustained interest in a little-known eighteenth century writer. This interest was ostensibly stimulated by the writer's special dramatic art but other information revealed a more personal reason. The writer was a thinly disguised

homosexual and his works eulogized masculine friendships. In real life he had been buffeted about by circumstances of every sort, and finally he ended his life by suicide. From childhood he had been supported by the love and faithful service of a slightly older sister who gave all, asked nothing, and was rewarded by ingratitude. The figure of this sister stirred the patient's enthusiasm as an ideal of womankind. In later life his attitude towards his own sister was a mixed one. A longing for her love and support was clouded by resentment arising from her preoccupation with her own affairs. Her life situation and responsibilities were far more difficult than his own, and from any reality standpoint the feeling of obligation should have been reversed.

In his sex life a curious incestuous complex was operative which was roughly the exact opposite of the normal, and equivalent to an inverted tribal taboo, whereby everything within the extended family group became a sexual object while outside contacts were forbidden. Towards the sister there had been conscious sexual feelings and at sixteen, excited by fantasies, he had risen from his bed and approached her room until with his hand on the door he was stopped by more sober thoughts. The few abortive sexual affairs that he had later were with relatives or the wives of his friends. In the recent years of his own wife's illness these incestuous trends more often came to the threshold of activity. Maids or nurses in the home came within the charmed circle, and he frequently escaped awkward difficulties by a narrow margin. In all these relationships there was a minimum of conscious guilt feelings and no need to justify himself by rationalization. The sexual claims were felt to be something of a right, and this viewpoint offered emphatic contrast to his conventional and rather puritanical attitude toward an alliance with any strange woman. This highly individualized moral standard in sex was rigidly isolated from any real influence in the analysis, and the most that could be accomplished was to achieve a meager verbal insight into its inconsistencies. The most dramatic examples of this upside-down incest taboo occurred immediately before

and after the death of his wife. Women friends and relatives, mostly with families of their own, offered sympathy, hospitality, and practical aid to the saddened and bewildered man. He accepted this service gratefully but in each case the situation was embittered for him by some actual rebuff or the knowledge that there was a limit to the generosity of these women at the border of sexual favor. To him this seemed hypocrisy, for they claimed love and friendship and yet thwarted him in the complete gift of themselves which he felt was most needed and deserved.

He was married at the age of twenty-five after a courtship pushed through to a vigorous conclusion but in which there had been considerable mixed feeling on both sides. There were no pregnancies, to the disappointment of both, and extensive medical investigation and treatment for both male and female sterility was carried out. Sexual adjustment had been difficult for the man. In the first months there was relative impotence but later the two felt that they had achieved a fair adjustment with mutual orgasm and psychic satisfaction. His impotence reappeared shortly after he learned that his wife was afflicted with an incurable illness, and soon became complete. This was not connected with a lessened physical appeal, but apparently had guilt connections with a newly mobilized hostility toward the wife whose approaching death in his eyes was equated with desertion. Physical sexual interest was complicated by ideas of dirtiness and by general anal depreciation of women. For example, an acute gastro-intestinal illness of his wife on their wedding journey, in which there was transient bowel incontinence requiring assistance from the husband, left a lasting impression. He said, 'You can never forget those things'. All odors connected with the feminine body he assumed to be anal in origin and in keeping with this premise certain elaborate sexual fantasies always began with a bath for the woman. Feelings of grievance and sharp criticisms towards women for the most part outweighed any tender and romantic feelings. In such things as physical make-up and dress the slightest deviation from the ideal took on enormous impor-

tance. Good housewifery, personal neatness, manner, speech, etc., assumed an obsessionally high place and any defection was unforgivable.

The wife came from a social and economic station superior to the husband's and her rôle towards him was in general a maternal one. By nature intelligent, positive and dominant, she was able to counsel and comfort the man who turned to her with all matters large and small. Until her final illness, she was robust enough by nature to avoid being worn down by the husband's querulous criticisms, his grievances and discontents about his work and outside life, and his endless entanglements in the petty details of daily living. There was another and brighter side to the picture for in many ways these people found much in common in their marriage and enjoyed many mutual interests. The two were unusually self-sufficient, preferred their own company in daily life and recreation and often resented the intrusion of the outside world through ordinary social obligations. They shared sufficiently the passion for neatness and order and the business of routine living arrangements to find no conflict on that score. Both were absorbed in the physical aspect of their home and gave sentimental and identification values to all their possessions. In a wider sphere, nature, books, music and travel brought them opportunity to share delights and satisfaction.

Some years before the wife's death the diagnosis was made of a disease that must inevitably be fatal. He was told of the situation and the wife must also have known of the outcome as she consulted medical text books. However neither consciously admitted the truth to himself nor to each other and life went on much as before. For several years the symptoms were not disabling and the two busied themselves with family, business and social affairs, and did much traveling together. Reaction of each to the husband's impotence was characteristic. The wife, though with sustained sexual interest, accepted the deprivation kindly. The husband concealed much of his underlying anxiety but made querulous complaints, often close to accusations that it was the woman's fault. He distressed his

wife by threats of trying out his powers with other women, but such intentions were never carried out despite her reluctant acquiescence. Several months prior to analysis, she developed alarming symptoms, which from then on required intermittent short periods of hospital residence and marked the beginning of the end. He was forced to face her impending death but to the last she spoke and behaved as if she expected to recover. This was more of an annoyance than a relief to the husband. He was forced to bear his sorrow without her accustomed support; he resented her optimism and what he felt was a foolish denial of reality. While avoiding open allusion to a fatal outcome, he managed to create endless, anxious, sentimental and recriminative scenes around subjects which were not far removed from the actual issue.

The depressive reaction by the time of analysis was unmistakable, although a working surface adjustment was still maintained. There were present the typical depressive mood, insomnia, self-depreciation, indecision, and preoccupation with ideas of suicide. Family and friends became alarmed and consulted psychiatrists who recommended analysis as an alternative to possible hospitalization. It was recognized that the situation was not favorable for formal analysis and the procedure was experimental. The patient undertook treatment reluctantly and was more influenced by the urging of his wife than by any interest of his own. However, he soon found it a useful outlet for his highly charged feelings, welcomed the interviews and used the relationship as a support, though not without criticisms of its inadequacy. Production was abundant and at first consisted of monotonous lamentations and complaints about the cruel fate that was snatching away his wife in her prime—all well seasoned with self-accusations for his own defects. He was critical towards everybody, with a minimum of insight, and his grievances reached almost paranoid proportions in relation to those he felt to be responsible for some recent enforced changes in his business status. His self-accusations centered around his irritations, his petty tyrannies and his lack of appreciation of his wife, together with his failure to attain proper

success in the business world. Often criticisms of his wife, eulogies of her character and virtues, and denunciation of himself followed each other in rapid sequence without clear lines of demarcation.

Ideas of suicide were a constant preoccupation. It never occurred to him that he would permit himself to live after his wife's death. The fantasy of double suicide predominated, and he had broached such a plan to his wife when she was first in the hospital. Her violent reaction of distress and resentment forced him to avoid further urging, but he kept the matter open with her by implication and elaborated it at length in his analysis. By her opposition to this plan, he felt that his wife had again failed him, and had done him an injustice. He could not understand why she, usually so logically minded, now preferred to fight a losing battle instead of doing what he considered reasonable, namely, to join him in death. His attitude was that she denied him the only thing now within her power to give. That this scheme of a suicide pact gave outlet for hostility and aggression seemed clear enough, and the wife's cry, 'Why do you torture me so?' had more real significance than either of them realized. In the last few weeks of her life following the onset of convulsions and other distressing symptoms, the theme changed to 'mercy killing'. He sought feverishly for all information on the subject, discussed the matter with physicians in charge, and in analysis railed against the conventions which interfered. In times between, in excesses of pity and loneliness, he bemoaned the fact that she could not be spared even for a little longer and railed against a destiny which had chosen her for sacrifice. In the analysis fault finding in all directions continued. When there was the slightest basis for complaint, he vented hostility and resentment against human beings, and when terrestrial themes were exhausted he deplored God and all His works. He communicated freely with the deity in a personal fashion akin to prayer but instead of being an expression of trust and appeal for help, it was a lamentation and an accusation.

Throughout these months he gave up work and devoted

himself to the care of the invalid. No task or trouble was too great, but he could not conceal his resentment and chagrin if some attention was unwelcome or unappreciated. He kept his wife at home at times when hospital care would have been simpler for all concerned. He was jealous of the nurses, and while he was exacting about their services he often insisted on doing things that they could do better. He felt injured when she preferred the nurses' more skillful ministrations and was puzzled and hurt when she said about a nurse, 'She wants me to live and you do not'. Self-pity was at times extreme. He said without insight, 'I feel like a little boy who is left by his mother'. He said, 'It is the good in me which makes me suffer so'. When people told him he was looking well or whenever he enjoyed a meal, he felt that he was 'standing my wife's illness better than I should'. There was an obsessive concern about his automobile's perfection of appearance and action, and towards this, as other property, there was an unusual quality of identification. In the first weeks of analysis there were several minor driving accidents, including an arrest for speeding, and on the way to an analytic hour he fell down the stairs in his home and received a painful injury to his arm. With reference to the damage to his automobile, an almost sensory empathy accompanied any marring of its shiny surface. The accidents brought up the immediate practical question of personal safety and led to a vigorous interpretation by the analyst of their self-induced character as manifestations of punishment and self-destruction. While there was no intellectual acceptance of such interpretation, a sudden change in driving care followed and through a winter in which he was constantly on the road, there was no important repetition.

It was interesting to see the evolution of his will to live. At first the slightest glimpse of the possibility that he could wish to survive his wife was reacted to with violent increase of self-accusations. 'It is the best part of me which makes me wish to die with my wife.' The desire to live showed 'miserable selfishness'. Later he felt he might continue to exist, not for himself but to live on as the man she would wish him to be,

or again, to be like her whose character he so much admired. Still later, and each time at the expense of a renewed flood of guilt, he wondered if he did not owe something directly to himself and have a claim to lead his own life. A month after his wife's death, while there was no decrease in expressions of sorrow and loneliness, the idea that he had no right to live had vanished. In the early part of the analysis identification with his wife was manifest in his habit of quoting her. Repeatedly he gave his observations and accounts of himself in terms of 'my wife said' and always presented this as the truth even if he was hurt and resentful at her plain speaking. These comments were often quoted from marital discussions and arguments that had been controversial and anything but friendly. The frequency of such discussions was facilitated by the fact that he was much about the house and his depression exaggerated and brought into focus all his obsessional traits and critical attitudes. There were long hours of introspective discussion about him. The wife's function was that of an amateur therapist who tried by ingenious superficial analysis and moral uplift to give him insight and help. Mixed with these motives was obviously something of her defense and criticism, springing from long-buried grievances. Later her main efforts were directed toward warding off painful scenes of sentimentalism and defeatism, with the 'let us die together' theme in the background.

Manifestations of anal character traits poured into the analysis. Pedantry, obsessive cleanliness and neatness, dissertations on waste, ritualistic behavior, and problems of money, played against a general background of criticisms and uncompromising judgments. All this did not prevent on occasion a really engaging and presentable social surface, and he was more sought than seeking in friendly social relationships. More directly from the unconscious particularly in the form of dreams, he betrayed anal-sadistic trends in thinly disguised form and also an increasingly regressive identification with his wife. Samples of some of the more significant productions are given as far as possible in chronological sequence. In the

beginning of analysis, six months prior to the wife's death, there was a sexual dream about riding on the back of a dog with a seminal emission as the beast fell dead of exhaustion. A few weeks later a dream with an unmistakable sexual theme was represented by crushing a dog's hind legs with an automobile. The wife's symptoms during this time included severe pains in the abdomen and legs and much bowel trouble. A long series of dreams and associations showed the patient identified himself with her. In one dream he had a pain in the abdomen, like his wife; in another, his hips were those of a woman. A month later he dreamed he had a pain in his leg, was examined by a doctor, and a diagnosis made of the same disease as his wife's. In another dream he was being taken in an ambulance to a hospital. Anal dreams in which tubes connected his wife's bowels with his, of douches which had both vaginal and anal associations and were being applied indifferently both to him and her, and a dream that his belly was full of cut sausages such as he had eaten the night before were numerous. In the last dream his abdomen was distended, as his wife's was actually, and he had to move very carefully to prevent an 'explosion'. (Deeper levels and connections of feminine identification were obvious enough from associations with this material but need not be followed here.) One night his wife had severe abdominal pains with constipation, requiring an enema in which he assisted. This brought mixed emotional reactions of pity, despair and resentment that she would not join him in suicide, and renewed anal depreciation. She seemed to him 'just a poor remnant of flesh that stinks'. That night he dreamed of a restaurant in which was a nude, repulsive, woman with a tail, 'something like chickens ready for roasting'. In another dream, associations with a disguised manifest content led to the wicked cities of the Old Testament, then to his own interest in the topic of Lot and his daughters, and the previous use of this fantasy in masturbation. Here it was fairly clear that the identification in the fantasy was with the woman and not with the man as he believed.

Two sets of castration-theme dreams played all through the

analysis and historically had long been recurring on a similar pattern. In one group the dreamer feared injury by small objects in his bed; in the other there was anxious searching for some article he had lost in his bed. In both groups, abortive somnambulistic attacks often accompanied the dreams and he would waken in a state of fear with the light turned on or find himself out of bed searching for something. In general, these two groups of dreams seemed to represent 'before and after' castration, and dream developments in both directions confirmed this opinion. In connection with the first, one dream took the form of a pair of shears cutting a blanket and threatening his genitals. In the other direction he awoke to find himself at an open window exposing his genitals. This and some actual abortive daylight exhibitionism seemed understandable as a denial of a castration threat.

Her last days and the actual death of his wife were met by him with unexpected resources. He was busy with infinitely detailed practical affairs, unwilling to accept help from others, and the analysis was briefly discontinued. Although he had free access there was no need to avail himself of any service from the analyst. Throughout this period and in the few weeks that followed, identification manifestations were dramatic but guilt reactions and punishment mechanisms much reduced. His hostility to women, as already stated, showed itself most strikingly in resentment at his women friends who drew the line at sexual favors. Towards his dead wife all conscious resentment disappeared. He idealized her in memory, gave long accounts of their life together, and revered all objects that had association with her. Occasionally, his depression reappeared, and he would lament that he did not die with her. All the beautiful things done or any pleasures that were made available to him by the efforts of his friends 'turned a knife in the wound'. A few days after his wife's death, he was awakened by a sharp pain in the groin on the same side where she had had local symptoms. He worried about appendicitis but the condition promptly disappeared and must have been purely psychogenic. He dreamed once

more that he had the same disease as his wife. In another dream he was having intercourse with her from the rear and he saw the buttocks, and recognized that they were his own. He prayed often that he might become a person like his wife or be the man that she had wished him to be. He held imaginary audible conversations with her and imitated her voice. He said, 'I feel as though she were in some way within me'. There was an increase in his obsessional personal cleanliness and he had feelings of a magical sort that by cleansing himself he would make women clean. One night he had a constipated and painful bowel movement, and apparently without awareness of any connection, narrated that sitting on the toilet he had an unusually poignant sense of his wife's sufferings.

There were a few dreams with manifest representation of oral incorporation. In one his wife was prepared for an operation, a large wedge-shaped piece of red meat was cut from her abdomen, and then put back again. Associations led to a piece of beefsteak of similar shape which he had prepared and eaten for dinner and he thought of the vulgar expression, 'There goes some good meat' applied to sexually accessible women. At this point he revealed that although in robust physical health he had been taking Blaud's pills and other medicines which had been prescribed for his wife and which he felt should not be wasted. The distribution of her personal possessions proved an enormous task in which he felt no one could help him, and in his hands this approached a ritual in which all these belongings seemed really a part of her. Specially difficult was the distribution of personal jewelry divided among close relatives in a ceremony carried out when all were gathered together. Afterward, dreaming of this scene, instead of jewelry he was cutting up salt pork for division among the group. The remainder of the analysis was uneventful so far as new material germane to this discussion is concerned. Some months after the loss of his wife, the patient moved to another city where a business opportunity awaited him and the analysis came to an end. According to information received during the

following year he managed well enough in his new position with no return of important depressive symptoms. There was little change in his general personality.

Reviewing the analytic experience of this man from the standpoint of therapeutic results, it seems probable the treatment saved him from more serious depression and perhaps resolved a certain portion of his identification with his wife. So far as could be directly observed, all that he gained was a useful insight into his reactions on pre-conscious levels. By constantly reiterated interpretation of specific material, he seemed finally to recognize that his grief was complicated by resentment at what to him was his wife's desertion, and in addition he could accept the fact that there was some kind of identification with her as a tragic and pathetic figure, ill used by fate. He also sensed vaguely his guilt reaction to some deep sadistic attitude toward women in general. From any dynamic standpoint the analysis was most unsatisfactory. The transference was weak throughout and it proved impossible to develop it satisfactorily in any direction, though there were revealed potentials on the pattern of the hidden father relationship. Concern on the analyst's part that the discontinuation of analysis might be reacted to in a depressive fashion as another deep frustration proved unwarranted. The patient seemed impervious to interpretations on any but the most superficial levels, and this was shown both by lack of intellectual acceptance and by the absence of confirmatory new material. His productions which revealed so clearly the operation of deep unconscious forces seemed nearly as plain at the beginning as at the end, and as oblivious to his comprehension. His attitude to the analysis as a whole was lukewarm and with the acute depression once out of the way, it is doubtful if there would have been sufficient incentive to continue.

To summarize the psychopathology in the case of this bereaved husband, it may be said that the samples of peculiarly naïve material presented in these notes are sufficient to show an open positive œdipus situation with rigid mother-sister

fixation. In addition, other material revealed an inverted œdipus problem somewhat further in the background. There was evidence of a strongly fixated anal libido organization which provided ambivalence in both directions, with resulting anal-sadistic depreciation of women overtly manifest, and a passive anal attitude to men concealed behind an obsessional and at times semi-paranoid façade. A marriage, in many ways fortunate for this neurotic individual, furnished him with a satisfactory mother surrogate toward whom he could act out some of his neurotic fixation. The wife's death reactivated the early mother relationship to still deeper regressive levels, and he clung to the lost object with attempts at anal and oral incorporation with the accompanying clinical picture of a depressive reaction. There were present suicidal ideas which plainly enough represented destruction of the object as well as his own punitive self-destruction. The facts so transparent in this case bear out the theories set forth by Freud on the identification mechanism in the depressions.

CHARACTER AND SYMPTOM FORMATION

Some Preliminary Notes with Special Reference to Patients with Hypertensive, Rheumatic and Coronary Disease

BY FLANDERS DUNBAR (NEW YORK)

Background and Present Importance of the Problem

That the time is not ripe for discussion of the rôle of character in symptom formation there can be no doubt, at least so far as our knowledge of it is concerned; yet it occupies a central place among the critical problems confronting medicine today.

In a recent paper entitled Psychoanalysis and the General Hospital [1] there are given some of the reasons why it has seemed that the problem should not be merely side-stepped or laid on the shelf until we have accumulated enough knowledge to be able to speak with authority concerning it. Not least among these is the increasing frequency with which the psychiatrist is being called on to cooperate with the general physician, or to serve as consultant in the general hospital.[2] Even more important is its significance for further understanding of organic disease. For these and other reasons it seems worth while to bring to focus some scattered fragments of relevant knowledge, together with some original observations made in the course of a general hospital study of patients with diverse somatic disorders.

By far the majority of patients with somatic disorders suffer from neurotic characters rather than full-fledged psychoneuroses or psychoses (in our material [3] all but about 10 per cent); hence, especially in the general hospital, the psychiatric con-

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[1] Read before the thirty-ninth meeting of the American Psychoanalytic Association, in Washington, D. C., December 27th, 1937.

[2] Cf. Dunbar, Wolfe, Tauber and Brush *(9)*.

[3] Cf. pp. 19–20.

sultant needs psychoanalytic training and some orientation relative to psychosomatic problems.

We are only beginning to gain an understanding that approximates etiological specificity in certain neurotic disturbances. Why one patient expresses his anxiety and his conflicts in action, another in psychoneurotic symptoms, and still another in what we have called 'organ neurosis' or in 'organic disease', is a very complex matter. The question as to why one patient develops one or another type of organic illness is just as complex. The answer lies probably in the various combinations of hereditary and constitutional elements, specific conflicts, and the total personality organization, plus possible adventitious factors. It is tempting to stop with a statement such as this but there are indications that in cases of somatic disorder where the psychic component is of determinative significance, it is of a specific nature for each disease entity thus far investigated.

Coincidences, Accidental or Relevant

It should be noted at the outset, that it is, of course, necessary to discard such expressions as 'psychogenesis' and 'psychic etiology'. The mistakes resulting from consideration of either the psychic or the somatic aspect of a disorder to the exclusion of the other are obvious. The chain of events leading to any illness is always complex and has both psychic and somatic components. The psychic component, however, is very frequently the determining one and of the same importance for prevention as is elimination of the typhoid bacillus from drinking water.[4]

A study of routine general hospital admissions of patients

[4] Even though the presence of bacillus may be considered not the sole cause of typhoid fever in any given case, Emerson *(10)* has pointed out that the bacteriologist 'no longer teaches that bacillus typhosus, for illustration, is the "cause" of typhoid fever. It certainly is the only known specific cause, nevertheless the chain of etiology of typhoid fever is made up of other links also, and among them some which he had named "immunity", "resistance", "susceptibility", etc., and these he knows, the affective psychical states of the patients can easily modify.'

with cardiovascular disease, diabetes, and fractures, has been carried out over a period of four years at Presbyterian Hospital. In addition, selected patients with these illnesses and with ulcer, allergy, and some skin lesions, have been studied over a period of nine years. In the course of this investigation [5] coincidences were observed and examined from the point of view of their relevance to the disease process under consideration. I shall try to summarize this material, covering in all 1300 patients, in terms of its bearing on the present problem.

Terminology and Approach

Anyone who has worked in the psychosomatic field has had occasion to realize to his grief the confusion wrought by careless use of such terms relative to the psychic component in an illness as 'character', 'personality', 'focal conflict', 'reaction patterns,' 'behavior', 'instincts'.[6] If we are to speak of specificity of the psychic component, we must be clear as to what we mean. In our material it has seemed convenient to speak of:

a Somatic makeup, including constitution, heredity, and specifically organ conditioning.

b Focal conflict plus factors in the patient's situation such as traumatic events, and specifically psychological conditioning.

c Fundamental character structure (genital, pregenital, etc.), strength of ego and the nature and strength of its defenses, that is 'characteristic' ways of handling difficulties or reacting to stress and strain, in both physiological and psychological terms. This is of critical importance for the psychosomatic problem as will be obvious since the majority of patients with 'organic disease' have neurotic characters.

d Possible adventitious factors such as exposure or economic handicaps usually evaluated in the light of the above.

[5] Under the direction of the author aided by a grant from the Josiah Macy, Jr. Foundation.

[6] Cf. Rado *(12)*.

It should be obvious that specific events in the external world such as economic hardship,[7] deaths in the family, or physical defect, can have no meaning for our problem except in terms of the above. And yet investigators in this field still try to correlate such factors with the development of disorders like arthritis or ulcer! On the other hand, considered in terms of the constellation—constitution, focal-conflict, character defenses [8]—our material (reported elsewhere) [9] gives evidence of specificity [10] of the psychic component for each of the disease groups studied,[11] and this impression is borne out by other investigators.

Now, because we know more about focal conflicts, and perhaps even 'constitution' than we know about the ego and its defenses in relation to somatic illness, I shall restrict myself essentially to this latter aspect of the problem. There are two

[7] Cf. e.g. Neustetter *(11)*, an interesting study indicating 'that poor social conditions are not in themselves a direct determinant of nervousness in children', and that 'poverty seems to decrease rather than to increase the incidence of many neuroses'.

[8] In many cases the same factors relative to this constellation have been picked out by way of Rorschach tests administered completely independently by an interested member of another department. Cf. the work of Hilde Bruch and Z. Piotrowski, personal communications in process of publication.

[9] Cf. Dunbar *(6)*; Dunbar, Wolfe and Rioch *(8)*; Dunbar, Wolfe, Tauber and Brush *(9)*; and Dunbar *(2)*.

[10] Cf. Zubin *(19)* for discussion of comparison evaluating similarities and differences.

[11] It should be noted, however, that sub-groups are in terms of the patient's symptoms, or of his subjective experience of illness rather than of the somatic disorder itself, and so sometimes cut across what we have considered 'organic disease entities', that is:

(a) Patients with specific syndromes such, for example, as exaggerated dyspnœa and palpitation, fall into the same group (with minor modifications to be discussed later) whether or not organic damage has taken place.

(b) Patients with such syndromes resemble patients with similar syndromes more nearly than they do patients with different disorders of the same organs. For example, patients with a well established syndrome of dyspnœa and palpitation (whether on the basis of rheumatic fever, valvular or myocardial damage, or no organic damage), resemble asthmatics more closely than they do patients with other cardiovascular disorders. Cf. footnotes 20 and 21, p. 34 ff., and Dunbar *(5)*.

types of observation far too rarely made which give important clues.

Reaction Patterns of Significance for the Somatic Disorder

Action versus thought and fantasy. Attention has been called to the fact that a mark of a strong ego is its ability to tolerate instinctual tension. We find that one factor in the type of somatic disorder developed seems to be the degree to which the patient tends to express his conflicts in action on the one hand, or in thought, philosophizing and fantasying on the other. In either case of course, the prominent pattern may be an attempt to meet the situation, to escape from it, or of oscillation between the two.

In another connection we have called attention to the prominence of the acting-out tendency in patients who are accident-prone.[12] These patients tend to escape from their emotional conflicts into action, or to express their aggression in impulsive behavior resulting in injury sometimes to others and usually to themselves. Fear and resentment is pent up and conflicts managed psychosomatically in different ways by patients with cardiovascular disease.

Sherrington's *(14)* analysis of the mind as essentially subserving an inhibitory function in relation to behavior is of interest in this connection because it means something to the general physician as an introduction to the additional comments the psychoanalyst would make concerning the psychodynamics involved. Sherrington notes that the greatest relief of instinctual tension is provided by action, the least by fantasy and thought, whereas speech stands half-way between. If tension is expressed directly in action, the action is likely to be ill-considered and to create situations injurious to the patient.[13, 14] If on the other hand, action is inhibited or

[12] Cf. Dunbar, Wolfe, Tauber, and Brush *(9)*.

[13] 'Speech, since it provides some degree of externalization of energy, may be regarded as standing between musculo-skeletal behavior (i.e. action) and thought, and is also a manifestation of partial motor inhibition. The degree of availability of these modes of cortical expression to the instinctual levels is in direct proportion to the degree of motor inhibition, because of diminishing

entered upon only after considerable thought and the suppression of emotion, the development of particular types of psychic or somatic symptomatology or both is favored.

In terms of this factor the groups of patients studied range themselves as follows: *fracture* patients (especially those with the accident habit) seem to have the greatest tendency to impulsive action and the least psychic elaboration in fantasy; then come *asthma* patients with their constant oscillation between action and its inhibition combined with a rich fantasy life; *hypertensive* patients show little tendency to impulsive action and relatively little psychic elaboration; patients with *arthritis* have little tendency to impulsive action but have a very rich fantasy life. These of course are merely general statements. There are examples of the opposite type in each group depending on the degree of over-compensation and the reaction-formations developed.

Spontaneous statements made by these patients are significant:

> The *accident-prone* patient says, 'I always have to keep working. I can't stand around doing nothing. When I get mad, I don't say anything, I keep it in and do something.'
>
> The *hypertensive* patient says, 'I always have to say "yes". I don't know why. I am always furious afterwards'; or 'I'm angry but I never like to fight. I don't know why. Something must have happened once.' 'Argument is my long suit. I could argue all day long.'
>
> The *asthmatic* patient says, 'Doctor, it's terrible; I don't know what I might do. I'm constantly on the verge of

external risk, yet the degree of relief of instinctual tension depends on the degree of sheer motor component in the expression. Thus action gives the greatest relief, thought or fantasy the least. But instinctual action carries with it the gravest external threat and thought the least grave. Speech stands midway between them with regard to both considerations, and is thus a singularly happy medium of expression. The symbols, the fantasies, with which the patient occupies himself represent a constant effort to translate the physiologic energies of instinct into a form adequate for cortico-spinal expression, or at least into the dissipation of pure thought.' Sherrington *(14)*.

[14] Cf. Dunbar *(5)*.

killing somebody or injuring myself, *you've got to* keep me from it, I'm not responsible for myself.'

The *arthritic* patient says, 'Everything I do hurts but I have to keep on moving'.

What does this mean to psychoanalysts? In general, the *id* is nonmalleable. The ego is adjustable. The organism needs defense against the strength of its impulses and against the outer world. There is in addition the superego. The significance and force of the superego in the human being comes not only from the complexity of his social life and his long period of immaturity and dependence but also from the fact that the parents (and ancestors) of men have a peculiar power. Man is the one animal that hands down experience from father to son in the form of the written and spoken word, and not merely by way of biological adaptation and the habits of the species. The very survival of each individual depends on his attitude towards and assimilation of this authoritative wisdom of the fathers; hence he has a superego with its peculiar pathogenicity when it is unassimilated. These remarks do not imply rigid topographical concepts but merely give an orientation for the material to follow.

Energy economy is determined by both the type and the adequacy of the individual's defenses. These bear a direct relationship to the type of illness developed as they do to vegetative phenomena. How are the characteristic defenses revealed somatically?

Degree and type of muscle tension. Patients whose dominant behavior is of one of the extreme types (action or its inhibition), of course have 'weak egos' but detailed understanding of their defenses is critical. Much too little attention has been devoted to these as revealed in postural attitudes, voice and muscle tension, and their relation to action on the one hand and fantasy on the other. As Freud, Reich and some others have pointed out, the musculature represents a sort of characterological armor; hence it should be of special interest to all psychoanalysts and to all students of psychosomatic problems. Muscle tension is a real psychosomatic borderline, a borderline

between instinct and outer world, restraining aggressive action toward the latter, and binding vegetative energy. Attention has been called elsewhere to the welling up of emotion that often comes when a patient is asked to relax.[15]

An obvious fact to which too little attention has been called is that all patients are not tense in the same way. Some patients who are tense show this in an appearance of stiffness, jerky movements, or a high strident voice, whereas others give no obvious evidence of tension so that one is surprised to discover in the course of physical examination how tense they really are. The former are usually called jumpy, nervous, hysterical, while the latter often escape notice entirely from this point of view. Among the former are those who tend to act out their conflicts in one way or another, and get considerable satisfaction from the attention paid to their symptoms. Sometimes they actually get themselves injured and sometimes they merely get sympathy for being such highly strung individuals. In general patients with certain symptom neuroses, allergies, and those who tend to have accidents, belong to this group. In some disorders localized spasms are prominent.

Patients with hypertension, gastrointestinal disease, or some other smooth muscle spasm, on the other hand, are likely to have a generalized tension which often escapes notice because of their appearance of quiet control. Patients in this group, furthermore, tend to give great attention to correct external behavior, and unless there is a marked accompanying symptom neurosis they usually dislike too much attention to their symptoms, and tend to go on in spite of them. They are likely to deny that they are nervous. This seems to be in part because these patients are universally afraid of their aggressive impulses. As already noted they are outstanding for the degree of their repressed or pent up hostility. Hence they are usually considerate of others and are loath to arouse criticism of any kind so that they try to conceal their tenseness itself. The question arises as to whether the necessity of subjecting to special control the manifestations even of their tension, which itself is serving

[15] Cf. Dunbar *(7)* and also Wolfe *(17)*.

the purpose of keeping aggressive thoughts and actions in repression, may not have something to do with the development of smooth muscle spasm. The tension seems to be driven inward to involve also the vascular or gastrointestinal systems. In any case, as patients are relieved psychotherapeutically of their symptoms we often see the process taking place in a reverse direction.

Patients with hypertension, for example, as they lose their symptoms, are likely to show an increased nervousness and jerkiness, and often say, 'I don't know what makes me feel so funny. I don't know what I might do.' These patients may become quarrelsome, show a tendency to get into fights or to have accidents, but in the end they show a poise and general ease involving a change in their breathing also, which is so striking that they themselves or their friends are likely to comment on it, usually in some such words as 'why you look years younger'.[16]

The nature of patients' tension is quite as significant for the somatic disorder as is quantitative predominance of specific trends and their expression through symbolically appropriate somatic channels. We have made reference to it previously in relation to an expression of analytic resistance and in relation to keeping material in repression.[17]

Descriptive Points Giving Clues to Psychodynamic Structure

General. In discussing psychodynamic structure, patients with cardiovascular disease, in the age group fifteen to fifty, will be chosen as central, and patients from other groups merely brought in by way of comparison. These patients (excluding for present purposes patients with cardiovascular syphilis, with subacute bacterial endocarditis, and with congenital heart disease, in our material less than 20 per cent) fall into four groups, if considered in terms of the subjective appreciation of the illness rather than the specific medical diagnosis. The groups are as follows: patients with hypertension; ('essential' or

[16] Cf. Dunbar *(4)*; Wolfe *(17)*.

[17] Cf. Dunbar, Wolfe, Tauber, and Brush *(9)*; Dunbar *(4)*; Wolfe *(17)*.

arteriosclerotic); patients with exaggerated dyspnœa and palpitation with or without organic damage; patients with marked pain, whether anginal in type (with or without coronary disease), or joint pains as in rheumatic fever,[18] and patients with recurrent decompensation. Each group presents different problems from the point of view of the psychic constellation in the illness and of management.

For the purpose of the present discussion the recurrent decompensation group will be omitted (decompensation is, of course, always the result of one of these other conditions) except to comment on the extreme importance of psychic factors in these patients and the difficult therapeutic problems they present. T. P. Wolfe has called attention to the fact that with these patients the psychic component often operates indirectly rather than directly.[19]

Hypertension. It is our impression (already reported briefly), apparently given general confirmation by Alexander and others, that hypertensive patients present an exterior characterized by a considerable degree of self-control and reserve. Their life history reveals indications of compulsive character and relatively few outspoken neurotic symptoms.[20] They are unlikely to express anger, at least, in the early stages (but when they do so the expression is usually explosive), and they often relate traumatic experiences with a good deal of calm indifference. The marked aggressive tendency has been more or less repressed although it seems always to be 'just below the surface', and

[18] Each of these subdivisions, however, has its own special characteristics.

[19] Note should be made of the fact that 'many of the physical symptoms, insofar as they are not the result of the organic lesion, are—although psychogenic in the last analysis—not the direct expression of an emotional conflict (as they are in conversion hysteria) but are caused indirectly. Such mechanisms are, e.g., decompensation in hypertensive cardiovascular disease, where decompensation and its various symptoms may be in no way a symbolic emotional expression, although the hypertension which leads to it may be of psychogenic origin.' Cf. Wolfe *(18)*.

[20] If Alexander's experience differs here it may be because he sees rather the exceptions than the general run of patients with hypertension, that is, the exceptions in whom neurotic symptomatology is manifest. Seeing all patients with a given disorder, such for example as hypertension, sheds light on the rôle of psychic factors in both the etiology and the course of hypertensive dis-

the opposite characteristics have been developed by way of correction or defense. Although this picture is the typical one (partly because in these patients the resentment is near the surface and little elaborated psychically), there are of course patients who present just the opposite picture, even to the extent of appearing to be libertines. In the typical case there is marked submission to authority (superego) as indicated for example in the characteristic statement cited, 'I always say "yes", I don't know why. Afterwards I am furious.' In a few cases where this element is less obvious there is still the marked conflict over passive tendencies and neither these nor the hostile impulses are given adequate expression. This can be shown to be important in the characterological armor or muscle tension which decreases as the inhibition of these impulses decreases. Some patients, with gastrointestinal disease, for example, seem to have a similar focal conflict but their psychodynamic structure, especially their expression of and defense against this conflict differ in several important respects, among which symbolization and fantasy are prominent.

Incidentally it is even easier to make these patients conscious of their fear than of their resentment. The fact that fear is relatively near the surface should be borne in mind by the physician. These patients, not knowing what the fear was originally, or really is now, are particularly ready to attach to it an ill-advised remark such as 'you have a very high blood pressure'. Telling such a patient to be careful very often suggests to him that the slightest exertion might make him die of apoplexy. In this way the physician himself may become a pathogenic agent.

ease. Patients with 'essential' hypertension seem to resemble those with serious arteriosclerosis or kidney damage in the constellation—constitution, focal-conflict, character defenses; the differences seem to be a matter of the relative prominence of psychic and somatic symptomatology, in terms of the inverse relationship, on which comment has been made so often. (Cf. Dunbar [2], p. xxxii.) It seems that the degree of expression or inhibition of the focal conflict, as well as hypothetical constitutional and other factors, may play a rôle in the rapidity with which the disease progresses and becomes structuralized. There is chronic rage, with temper tantrums in childhood, later more or less completely repressed or expressed in less obvious acts of rebellion.

In brief then, leaving aside constitution and focal conflict, these patients have very characteristic defenses.[21] They are not active, or act only explosively (occasionally one of them has a purposeful accident), and they are always tense. The tenseness which is of both skeletal and smooth muscles, is part of the attempt to inhibit, and a defense against, both action and fantasy relative to their chronic rage. It decreases as this conflict is brought up and worked through, rendering the defense no longer necessary; hence, perhaps, the frequent return of the blood pressure to normal with such therapy.

Syndromes characterized by dyspnœa and palpitation. General findings in this group also have been discussed in another connection.[22] The following points may be noted for the present purpose:

First, whereas a compulsive character is a general finding among patients with hypertension and some develop compulsion-neurotic symptoms in the course of treatment, patients with marked symptoms of dyspnœa and palpitation are characterized by phobias and prominent conversion mechanisms. The mechanism is sometimes genital, as in hysteria, and more often pregenital, ranging towards that characteristic of the asthmatic, but there seems not to be such a marked prominence of anal material and oral character organization on the one hand, and of the tendency to act out aggression on the other, as is found in asthmatics.

Second, in no group of patients with actual structural damage is what we have called the pseudo-hereditary factor so important. Even where the dyspnœa and palpitation has as its basis rheumatic

[21] Inasmuch as these patients have been described more fully than have the other groups, it seems inadvisable to give them more space in this context (Cf. Dunbar, Wolfe and Rioch *8*; Dunbar *5*). Cf. also Psychosomatic Medicine, Symposium on Hypertension *(15)*. Scupham, de Takats, Van Dellen, and Beck *(13)* presented the literature relative to vascular disease, noting that sympathin and epinephrine may be factors in the vascular spasm which is fundamental to hypertension, and that both are discharged into the blood stream with emotional excitement as well as with 'hypoglycemia, cold, pain and vigorous muscular activity'. It should be noted that the extreme tension of the skeletal musculature produced in the attempt to inhibit action (as well as emotional excitement) brings about this same effect. Thus whatever the physiological mechanisms involved, psychic factors may be of etiological importance.

[22] Cf. Dunbar, Wolfe, and Rioch *(8)*.

heart disease and myocardial damage, this symptomatology is much more marked in those who have been exposed to parents or friends with such symptomatology. Attacks may be precipitated by such exposure whereas it is unusual to find that an accident to a fracture patient has been precipitated as a reaction to an accident on the part of a friend.

Third, diseases of childhood play an important rôle seeming similarly to give psychological prominence to certain types of symptoms as well as physiological preparation for them. These may serve as prodromata of the cardiovascular symptomatology. This element is particularly marked if the symptoms are out of proportion to the structural changes and attention has been called to the fact that in asthmatics (F. Deutsch, Dunbar and others) there is usually a history of repeated croup and pertussis and sometimes bronchitis. We find this in these patients also.

Fourth, the symptom complex has a definite significance to these patients, usually in terms of the œdipus situation and of the tendency to identification with the mother, together with the need to break away and take revenge. Dreams of smothering and a tendency to claustrophobia are characteristic. (The group of patients with cardiac pain either in addition to or apart from dyspnœa and palpitation, seem to show a still greater tendency to anxiety hysteria.)[23] It may be noted in passing that although these patients may have either agoraphobia or claustrophobia the great majority of them have claustrophobia and tend to avoid acting out their fantasies. Fracture patients on the other hand tend to defy their agoraphobia and their fears of falling and have many accidents on the street and by falling from high or low places.

Fifth, in the presence of severe organic involvement, relief of this symptom complex may be of importance to life, and it is always important in the prevention of invalidism.[24]

Sixth, as with hypertensives, symptomatic relief is sometimes readily produced by superficial psychotherapy.[25]

Seventh, anxiety neurosis (especially if an important aspect is poor sexual hygiene) is a complicating factor of great physiological importance and is often readily eliminated.

[23] Cf. Dunbar *(3)*. This picture is not identical with the submission to the parent, characteristic of the hypertensive.

[24] For discussion of this material Cf. Dunbar *(2)*; Wittkower *(16)*.

[25] Wittkower calls attention to this finding in patients with organic pain.

Comparison of these patients with the fracture group brought out marked differences both in reaction type and in history. Even though we bear in mind the question 'is the coincidence accidental or relevant' it is worthy of remark that ninety per cent of the latter (about one hundred and fifty cases) gave a history of stern parents (or foster-parents) both of whom lived into the patient's adolescence, and of strict religious upbringing. Of this group of cardiacs on the other hand (same number of cases), although brutality on the part of one parent or the other was often reported (40 per cent), only two per cent reported strictness on the part of both father and mother, and interestingly enough, in only three more cases was the mother strict or violent with the children. (In one of these three the mother had cerebral syphilis and in the other the mother was alcoholic.) Usually there was a very marked attachment to the mother on the part of both males and females, accompanied by fear of the father, or absence of the father as a result of death or divorce. Relative to religion also there was a marked difference. Relatively few of those with cardiovascular disease had retained a definite religious 'fixation'.[26]

Leaving aside constitution, possible adventitious factors, and focal conflict (the difference in the latter has been suggested), this group differs from the hypertensive group in the tendency to impulsive action and in fantasy life. Their symptoms have meaning in terms of psychic conflict that is more elaborated. The accompanying disturbances in the muscular armor are more of the nature of localized spasms which are likely to have psychic meaning, and the general tendency is towards jerky, hysterical behavior. It is probably important to note that the heart itself is an organ poorly suited to become the focus of fantasies and is usually involved in more direct expression of anxiety. This may be one reason for the frequent involvement of the gastrointestinal or other systems in this group of cardiacs. In any case, they are likely to have fantasies

[26] Cf. Dunbar, Wolfe, Tauber, and Brush *(9)*.

related to gastrointestinal disorder. In hypertensives the frequently accompanying constipation is much less likely to be accompanied by fantasies, and seems to be rather a part of the generally exaggerated tension of both smooth and striated musculature in relation to inhibition of hostile impulses.

Syndrome characterized by (a) joint pain. Unlike the two groups just mentioned, patients whose symptoms are mainly joint pain show a tendency to symbolization of the sites of pain, and a rather typical fantasy life. The following excerpts from the analysis of such a patient are characteristic:

> 'I dreamed that a cat jumped up and clawed my right arm so that I thought I would bleed to death.' When the patient woke up her arm was paralyzed. She had shown a tendency during the past week to rub her feet together, to rub her fingers together, to rub the hair on her head in little circles, but no comment had been made on this behavior. On this particular day the patient said: 'I suppose you think when I do this I am masturbating, but I don't see why you don't say something about it.' She said: 'Doing this with my right hand really hurts because of my arthritis, but it hurts *just enough to be comfortable*'. In this patient the feminine rôle was bound up with suffering. Mutilation was an important theme in her dreams and to some extent acted out. She had suffered for six years with fairly severe arthritis, especially in the right arm and hand so that she was unable to write. This was the masturbation hand. Also her grandfather had lost this arm and hand and an uncle had lost a finger of his right hand because of being scratched by a cat. She herself had lost part of a finger on this hand because of having allowed an infection to go uncared for.

In association the patient said: 'I've spent hours this week in trying to write. I can't get anything out. I nearly go mad faced with blank stretches of hours. I must but I can't. I feel like doing some real injury to myself, biting my little finger to break it the way mother broke grandmother's finger when I was born.'

Later she dreamed:

'I gave mother an overdose of sleeping powder and then it seemed as though someone had given it to me and then just as everyone thought I was dead my right arm began jerking and it jerked so hard it waked me up.'

At this time the patient's arthritis was so severe that she was unable to turn a door knob or to eat with her right hand. Shortly before the arthritis finally cleared up (and there has been no recurrence of it), she had the following dream:

'A disembodied arm is lying in my lap and I am admiring it. Someone has just said how strong it is and I am surprised to have an arm with so much muscle. I was particularly surprised because it was my right arm in which I never used to have any strength. Then I noticed that the arm was solid gold and I said that perhaps I had found the pot of gold at the foot of the rainbow. Just then I heard a moaning voice say, "Who's got my golden arm? Who stole my golden arm?" I was filled with horror and thought it was a ghost creeping down the hall like the ones I used to be afraid of in grandmother's house.'

This dream is sufficiently obvious to need no interpretation. This association of arthritic pain with masturbation and restraint or punishment is a general finding in both men and women, the focal conflict, like that of the asthmatic, being related to the sexual rôle.

Interestingly enough, even in children and adolescents suffering from their first attack of rheumatic fever the conflict over masturbation and fear of mutilation or death as a punishment therefor, together with conflict over the sexual rôle, male or female, as the case may be, is very prominent. Girls are inclined to be tomboys and boys to be passive.

Strictly speaking, patients suffering from acute rheumatic fever should be treated separately instead of being classed with patients who have rheumatoid arthritis. It must be added however, that there seem to be differences in the psychosomatic constellation, especially the character defenses, in those with cardiac involvement as compared to those without.

Leaving aside constitution and adventitious factors, these patients differ from the previous groups in focal conflict and in defense mechanisms. Their somatic symptoms have psychic meaning. They are of an incapacitating as well as punitive nature, such as at the same time to satisfy the impulse in question in a round-about way. Many such patients have compulsions to keep doing things involving the injured joints and even to 'crack' the joint, and seem to derive reassurance from the resulting pain.

Syndrome characterized by (b) anginal pain. Patients with coronary disease and pseudo-angina present a complex picture in which vascular and muscle spasm related to repressed hostility is marked. They show also a prominent sense of guilt and tendency to self-punishment; they are the only group of patients with cardiovascular disease that seemed to show any considerable tendency to have accidents prior to the onset of illness except perhaps the hypertensives, who resemble them.

By way of stressing further the necessity of looking for specificity in material such as this, rather than in case history material representing factors of which the patient is conscious, the following two histories of patients with anginal syndromes are given. One had coronary disease, the other showed no organic damage. These case histories are identical down to the most minute details yet in terms of such factors as those here mentioned there are some important differences. They illustrate also the fact that descriptively and psychoeconomically, patients with similar syndromes, including psychic and somatic symptomatology, have important similarities in personality and history, at least on superficial study, whether or not organic damage has taken place.[27]

With organic disease: A married man, age 32, pyknic in type (Jewish), was admitted to the hospital after dinner one eve-

Without organic disease: A single man, age 24, asthenic in type (Jewish), was admitted to the hospital suffering from pre-

[27] These cases were worked up and treated by Dr. Edward S. Tauber under the supervision of Dr. Theodore P. Wolfe and the author.

ning in severe pain, substernal radiating to the episternal notch and the right elbow, relieved only after 'three hypodermics' (Magendie).

Onset: On the day of admission he had supper at his mother's house. The mother, in her customary oversolicitous manner had inquired about his health. He said: 'I never felt better in my life. I feel as muscular and strong as can be.' 'Strangely enough', he added, 'that night I got sick.'

The first symptoms had been substernal pain and oppression with belching four months previously, since which time he had been treated by doctors for 'heart trouble, indigestion, or some other illness.'

cordial pain radiating to his right arm so severe that it made him double up.

The immediate onset had been after dinner while he was seeing a war movie with his girl friend where he began to develop a slow insistent stabbing type of pain. This patient also made the comment on the evening of admission that he never felt better in his life, having just returned from a vacation which he had taken in order to recover from his previous attack which he describes as follows: 'I was at a roadside restaurant with mother and father and suddenly developed this awful pain. I remember I was eating a cheese and ham sandwich, and had a glass of beer, something I never drink.'

The first symptoms: In this patient also the sudden onset of sharp precordial pain was the beginning of a series of experiences with the medical profession (although interestingly enough his 'heart condition' was taken more seriously than in the former case). He went immediately to see a doctor in the neighborhood (1) who told him it was 'probably indigestion' and 'it was all right',

and gave him some medicine. A week later, still having his pain, the patient was seen by his family doctor (2) who said 'It's your heart' and ordered two weeks bed-rest. After these two weeks, he went to see a specialist (3) who told him 'his heart was all right'. Several weeks later, however, a complete work-up and an EKG showed 'slight irregularities' which were interpreted to the patient as meaning that he had 'a muscle strain leading to his heart'. He was told to stay in bed for an additional seven weeks, after which period of rest he was told that there was much improvement in his heart. However, the patient became 'worried sick', tense and restless. Nevertheless, he went back to work and continued more or less uninterruptedly until a year and a half later when he had a mild attack lasting several days of the same type of precordial pain. He went to see his local physician who told him that his heart had developed a bad murmur in the last two years. The patient was advised to be on a strict diet and to get a good deal of rest. Again he became very much worried over his health, and lost it as he always did when he worried a great deal. He saw two other doctors (5, 6) who reassured

him, telling him that his heart condition was functional, and that most of his trouble was 'nerves', but by this time he was so scared he could not believe them.

Heredity, pseudo or otherwise and family adjustment: The patient's oversolicitous mother, age sixty, had thought for sometime that she *might have heart trouble* because she had pains in her chest. The patient's father died at twenty-seven when the patient was three years old, having suffered from sunstroke one year before his death, relative to which both patient and mother had strong feelings.

Heredity, pseudo or otherwise and family adjustment: The patient's mother, age forty-eight, was oversolicitous and complained of pains in her chest which she thought *might be heart trouble.* The patient was an only son (having one older sister who was married just prior to the patient's admission to the hospital). The patient's father, forty-eight years old, in the insurance business, had an emotional make-up so much like that of the patient that a friend remarked: 'It is clear they could not get along together'. Although he had always been well, the father some months before the patient's admission to the hospital had been brought home from the golf course in a state of *mild sunstroke* concerning which the patient said: 'I could feel my stomach contracting, and was slightly nauseated. I felt as if things were moving from my abdomen up to my chest.' A paternal uncle, age fifty-six, dropped dead of heart disease just after the onset of the patient's symptoms.

Neurotic trends: The patient, an *only* child, was always sickly, suffering frequently from sore throat and upper respiratory infection. He bit his nails until the age of fifteen or sixteen. The patient always smoked a great deal, and claims that he *knew something would happen to him for smoking so much.* This smoking was of rather compulsive kind, in that he did not really enjoy it; it frequently made him feel nauseated, but he 'did it to avoid getting *something to eat between meals* when he was hungry', (i.e. compulsively), and he stated that *his mother always felt that he might get sick from smoking.* The patient also had a particular attitude towards *eating.* Even when he had no appetite if his wife made a good steak he would eat. He thinks that eating when he was not particularly hungry may have harmed him, also that nocturnal emissions probably weakened him. During his stay in the hospital he used to be awakened by erections and asked to have saltpeter in his diet.

Sexual adjustment: The patient suffered from *premature ejaculation* and impotence. His marriage is patterned after his relationship with his mother. He married a few years before

Neurotic trends: This patient also bit his nails and had temper tantrums which, however, he said did not last long. 'They were beaten out of me by my father.' He noted that when he was upset he had *urinary frequency* and gas that formed in his stomach so that he would have an urge to defæcate although he had always suffered from severe constipation. He was inclined to relate his troubles to *eating.*

Sexual adjustment: This patient also had casual heterosexual relationships at the age of fifteen, after a period of masturbation and suffered from *premature ejaculation.* In this

his illness. He had begun masturbation at the age of thirteen, and heterosexual relationships never with a 'nice girl'; his marriage was essentially against his wishes. ('I disliked losing my freedom.) He married because he 'felt obligated' in view of the fact that he had 'strung along' the girl, and she had requested him finally to marry her. The patient stated: 'I think of her more as my mother, really, than anything else. She treats me like a little boy, and I like it. She tweeks my nose, and tickles me, and has had a baby picture of mine enlarged which she calls Bubi.' She is very protective and on one occasion she wanted to beat a man who was about to get into a fight with her husband! The patient has had no extra-marital relations because he thinks it is cheap and because *if his wife found out she would 'beat him up'*. In view of his liking for being babied it was not surprising to find that after a while the patient stated that he was beginning to enjoy hospitalization and did not feel eager to leave the hospital. He had a stereotyped dream: in the midst of business negotiations, looking at his watch he said, 'It's late. I have to get back to the hospital.'

connection it is interesting that the summer before his admission a heart specialist advised him to get married.

The patient had been engaged for two years prior to his illness to a wealthy girl to whose mother he was very much devoted. The girl's mother, however, robbed him of some three thousand dollars worth of commissions to which he was entitled for handling her investments, and gave the responsibility to someone else. He never mentioned his anger over this to either mother or daughter, separated from the girl, gave up working with his father, and developed precordial pain. The fact that the patient never gave vent to his feelings toward his father may deserve stress. 'I would just get burned up inside. Shut up and not say anything for days at a time.' This has apparently something to do with his temper tantrums at the age of five which 'were *beaten out of him by his father*'. This situation is a common finding in the anginal syndrome: hatred and resentment which is being kept repressed instead of being given expression. The situation with the father was accentuated by his experience with his prospective mother-in-law who cheated him out of the

Vocational and social adjustment: The patient worked in the *insurance business* and when he lost his job (apparently through no fault of his) he took odd jobs, and in June 1936 was given the position of *gym teacher* in a WPA project.

He always liked outdoor sports, but disliked hunting and fishing, stating that he *could not bear to kill an animal.* He said that if anyone ever harmed an animal he would kill him, because he hates to see blood—'that is, animal blood'. He told of an incident in which a shepherd dog with which he used to walk through the field in summer, caught a bird and killed it. He tried to get the bird away from the dog because he *hates to see one animal kill another.* An interesting incident occurred several years ago when the patient was in a bakery shop, and a dog belonging to the baker growled at him and took a nip out of his leg. The patient told the baker to call off his dog, but the baker was amused and did

proceeds of his hard work. Here again, he got all 'balled up inside', not saying anything about it to anybody. Then came his sister's marriage, his father's sun-stroke, awakening his sense of guilt, his uncle's death and the confusing statements made to him by doctors.

Vocational adjustment: The patient's first attack of pain, although it occurred immediately after a meal, occurred also immediately after he had given up working for his father in the *insurance business* because they 'couldn't agree'. There were many violent conflicts which bore a relationship to his symptomatology.

nothing about it. The patient grabbed a large knife lying on the counter and started for the dog. A short time later a girl in the neighborhood was bitten by the dog, and the patient was called to court to testify against the defendant. He was almost given thirty days for *contempt of court* when he became flippant with the judge. The patient described himself as being very quick to anger and extraordinarily *sensitive to pain,* enraged by the slightest inconsideration. He never gave expression to his anger in a straightforward manner however, but in such devious ways, as for example calling a man who had changed his name to Stedman Coles, 'Simon' or 'Kohn' in the presence of groups of people. He held grudges for a long time, and enjoyed revenge. His repressed aggression showed up constantly in his dreams which were full of fighting and arguing. One night he dreamed that he was walking along the street, and that some friends were fresh with him. He ran over and struck one in the jaw. A policeman came up and the patient said that he had just got out of the hospital and was weak, otherwise he would *really have been able to beat up the whole bunch.*

Course of illness: The patient was discharged from the hospital three months after admission. The discharge note says: a case of classical coronary thrombosis unusual in such a young man; blood pressure was 155/110. He returned to the hospital at the end of two weeks and then again after three more weeks at which time psychotherapy was undertaken. He was seen seven times and has been followed at intervals of a few months for nearly two years. He has remained without symptoms during this period and able to be somewhat more active.

Course of illness: Admission diagnosis was rheumatic heart disease, inactive (?), subacute endocarditis (?). The patient was discharged two weeks later as having no organic disease. Pneumothorax of the left apex was discovered during the hospital admission, after the patient had been in for about ten days. He had psychotherapy from the start, and has remained free of somatic, although not of psychic symptomatology, for nearly three years to date. His economic condition and the necessity of going back to work made it impossible for him to have more than eight periods of psychotherapy.

Such case histories as these show clearly the need of more than superficial psychological study. These two patients were *similar* in heredity, position in the family, type of mother, attitude toward the father (both fathers even suffered sunstroke). These patients were similar in their marked oral component, oral dependent attitude, sexual conflict and inadequacy. Both were compulsive. They were similar in having been exposed to relatives with cardiovascular symptomatology, and in the situations which were the precipitating factors in the attack that led to their hospitalization. It should be noted that both patients have remained symptom free, apparently as a result of psychotherapy, which however, was obviously inadequate and directed merely towards the symptom complex most closely related to the organic symptomatology.

There were the following overt *differences:* the case without demonstrable organic damage was 8 years younger and of different constitutional type, but he had actual cardiac heredity whereas the one *with* organic disease did not. In the case with

organic disease the father died when the patient was three years old, whereas in the case without organic damage the father was living and in consequence the patient's hostility toward him was constantly brought to the surface and to some extent acted out. Did this have anything to do with the fact that in the latter the hostile and sadistic impulses were nearer to consciousness than in the former, with his more passive attitude and his fear of blood? Berliner *(1)* has suggested that 'there are deeper conversions which affect not only the functions but also the structure of organs and which apparently come into action, when a strong superego drives the ego into deep pregenital regressions, to a level where psychic and physical functions are less differentiated.' The literature contains many suggestions to this effect. Furthermore, the patient with organic damage had sufficiently repressed his difficulties to allow himself to be married, although 'against his wishes', and to accept a completely passive rôle; the patient without organic damage, although constantly forced into a passive position, was still fighting. This is not at variance, as might appear, with the fact that the hypertensive's blood pressure decreases when he gives expression to either his aggressive or his passive impulses.

These two patients illustrate, also, the difference in behavior between the patient with organic heart disease and the neurotic patient with cardiac complaints to which his attention is repeatedly called. Whereas the patient without organic disease always expected the doctors to find evidence of organic disease, the patient with organic disease stated that after discharge from the hospital he wanted to check up on the diagnosis because he did not feel convinced that he had heart trouble even though he thought that 'the doctors at the hospital were very capable'!

Do these differences have anything to do with the course of illness in the patients concerned? Is it possible that the second patient will return sometime within the next few years with coronary damage? We can only agree with Pascal that *'Le cœur a ses raisons que la raison ne connait pas.'*

Summary and Conclusion

I On the basis of a study of some 1300 cases (covering five different types of somatic disorder) material has been obtained indicative of differences in the constellation—constitution, focal-conflict, character resistances—for each of the groups studied and for subdivisions of the cardiovascular group. This has been illustrated in the present paper with special reference to cardiovascular syndromes.

II Emphasis has been laid on the third element in this constellation (character defenses) because of its rather general neglect, and the significance of its diverse physiological manifestations.

III There has been no intention to do more than give a superficial picture with suggestions. All of these however have been checked by psychoanalysis of individuals in each group. We may note that valuable as it is for us to coöperate with our colleagues in other branches of medicine, it is even more valuable to increase our understanding of disease. An important step in this direction is careful observation by psychoanalysts of somatic occurrences in patients that come under observation.

IV Some suggestive points may be summarized as follows. Most fracture patients, like hypertensive patients, have a focal conflict over submission to authority and marked hostility. One expresses this in action, another in an attempt to inhibit action. The one has a jerky spastic type of tension, the other generalized tension involving both skeletal and smooth musculature. Both the disturbance in muscle tension and the tendency to impulsive action or inhibition of action are relieved by the working through of this conflict, even without complete correction of the personality disorder. It is possible in many cases to interrupt the accident habit or to bring about a return of blood pressume to normal in this way.[28] Patients with

[28] For a case report cf. Dunbar *(3)*. The hypertensive patient here reported is still being followed and has maintained the normal blood pressure level to date of printing, i.e. for some nine years.

marked syndromes of dyspnœa and palpitation and patients with arthritis show similarities in focal conflict against which they have developed different defenses. They differ in both these respects from hypertensive and fracture patients. Their defenses seem to bear a relationship to their symptomatology.[29] In the two case histories of patients with anginal syndromes, one with and one without organic damage, we see a striking similarity in history and focal conflict, but a difference in constitution and in expression of the conflict. These comments are of course, all tentative and merely suggestive.

V It must be stated emphatically, as I have done before, that in any general statements made, the intention is not to relate the characteristics set down exclusively to the somatic syndromes in question, that is accidents resulting in fracture, asthma, and various types of cardiovascular disease, but merely to note that they have been found in these patients, as of course also in many others, but in varying degrees of prominence as one of these groups is compared with the other.

A difficulty with general hospital material lies in the fact that many patients go to the general hospital only in time to die. It is obvious that little or no evidence can be obtained from such patients concerning the psychic component in the illness although findings in patients with the same illnesses, hospitalized at an earlier stage, suggest the importance of psychic factors in the others also. Our evidence is to the effect that fewer patients would reach advanced stages of these diseases had we more knowledge of the type just indicated. Such knowledge would greatly increase our efficiency and decrease the time expended in therapy and prevention.

VI The material given demonstrates once more the fact that treatment should be instituted in the minor illness phase, and that the treatment should be as nearly as possible etiological in both its somatic and its psychic phases, not merely symptomatic or palliative; not merely a matter of either forgetting the patient or keeping him 'under observation' until organic

[29] For case illustrations showing this more clearly and giving therapeutic results cf. Dunbar *(5)* pp. 41 ff., and Dunbar *(3)*.

damage has taken place. It is only in this way that we may hope to cut down the ever increasing bulk of chronic illness and to deal adequately with the illnesses which are now our major causes of morbidity and mortality.

In brief then, although methodology is still undeveloped, it is our impression that much can be learned from the recording of sequences observed through the lens of the best methodology of physiology and clinical medicine on the one hand, and psychoanalysis on the other. On the basis of such material coincidences can be observed which may be either accidental or relevant to our problem. As the number of cases studied increases, and the period of follow-up lengthens, it will be increasingly possible to ascertain which alternative is the case and why.

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OBSERVATIONS ON WORLD DESTRUCTION FANTASIES

BY WILLIAM J. SPRING

The idea that the world is coming to an end, or has already done so, is one which is frequently met in schizophrenics, particularly in the early stages of the illness. This idea may take the form of a fixed delusion or of an anxious obsession. In its details this idea varies tremendously. Earthquakes, floods, wars, revolutions or pestilences may be held responsible, or specific descriptive details may be entirely lacking. At times the destruction is represented by lesser catastrophies in which nations, or merely cities, are destroyed. These ideas have in common that large masses of people are wiped out, usually the whole human race. Often variations of this idea occur in the same patient.

The theoretical importance of this idea for an understanding of schizophrenia was first pointed out by Freud in his well-known discussion of the Schreber case.[1] He showed that Schreber's delusion that the world had been destroyed was the projection of an inner catastrophe, the withdrawal of the patient's interest or libido from the real world; that for the patient the real world was destroyed since it no longer had any meaning for him. The discussion by Freud affords a deep insight into the rôle which this fantasy plays in psychosis. The patient expresses the withdrawal of his libido from the world of objects by a feeling that his world of objects has come to an end.

The aim of the present paper is to inquire into the rôle of this fantasy in the psychic lives of patients. In what situations does it arise? What instinctual wishes does it gratify?

[1] Freud: *Psycho-analytic Notes upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides).* Coll. Papers, III. London: Hogarth Press, 1933. pp. 390–467.

How does it happen that these wishes are gratified in this particular way and what relation, if any, can be established between the idea itself and the situation which gives rise to it? If these questions can be answered, a step will have been taken in the direction of understanding the actual dynamics of the world destruction delusion and of the withdrawal of libido from real objects, which is generally held to be responsible for the phenomenon. This presentation represents only an approach to this problem, an attempt to bring together a group of more or less fragmentary observations on fantasies of world destruction as they were seen on a clinical psychiatric service.

Probably the simplest working hypothesis with which to approach the facts is to assume that like other delusions and obsessive fears, the idea that the world is coming to an end represents the fulfilment of a wish, an idea that has already been suggested by Reik. Let us turn to the clinical facts.

In some cases it is quite apparent that the destruction of the world represents a wish of the patient's since it is uttered as a direct threat. For instance, a patient remarked, 'The world is all ready to be destroyed. I can release the energy in an atom.' At another time while angry at being kept in a prolonged bath, the same patient said, 'At ten minutes after five I'm going to blow this place up.' Asked if he meant the hospital, he replied, 'Yes, this hospital and the whole world. Going to blow it up to hell.' Another patient repeatedly used the threat to put an end to the world in order to enforce minor demands. For instance, 'If you don't let me out, the results may be very grave, not only to you or to Dr. B., but also to the whole world.' This same patient once demanded a cathartic be given to him secretly. When the doctor hesitated the patient said, 'It's a matter that affects the whole world.' In these cases the idea of destroying the world appears as a simple expression of anger, the anger itself having the most obvious motivation in everyday frustrations. Somewhat similar is the following case. A patient

said, 'While I was at school two Italian boys fed me candy which was full of syphilis and I have poisoned the whole world.' Here the motive is revenge for a delusional injury.

That patients themselves sometimes realize the fantasy of world destruction as their own wish is shown in typical guilt reactions which one occasionally sees. A patient said, 'Because of me the whole world won't be able to exist. I can't eat.' Another time the same patient said, 'I'm always like a tiger here. I don't know, doctor, but I am worse than a killer. It feels as if there is something like destroying the whole world. I should ask for forgiveness. I shouldn't pronounce the name of God.' Here the wish to destroy the world is recognized as a wish to murder and it is treated like one. This patient expressed the same idea repeatedly in slightly different words. Another patient, after hearing on the radio a series of Buck Rogers sketches in which there occurs a 'mad professor' who repeats the words, 'Prepare for world destruction', began to worry that he himself might study sufficient science to enable him to destroy the world. He was sincerely afraid he might do this and developed a real moral struggle about it. He begged me to help him to resist the temptation to study science and destroy the world. Though he is schizophrenic he makes use of devices similar to those utilized by phobics and compulsive neurotics to defend himself against this drive to destroy the world. Thus he avoids reading science because he fears this will lead to world destruction, and he carries out ritualistic prayers for the good of the world. Usually the repressed breaks through however, and he discovers that a trouser button was unbottoned while he was praying or an evil thought crept in, which reverses the desired effect of his prayer. It was such a slip he thinks which was responsible for the Morro Castle disaster.

Another patient who also exhibited compulsive behavior suddenly remarked, 'The whole world is going to pieces in ten minutes. I could have saved it. Something told me to touch a plate but I didn't do it. I'm going to die and when

I die the whole world is going to pieces.' He refused to elaborate this statement.

The delusion so frequent in paranoid schizophrenics that the patient has been chosen to save the world, appears in some cases at least to be a reaction-formation against wishes to destroy the world. A college student, who later in his psychosis believed that a series of wars would destroy the human race and all the animals and would probably injure the planet itself pretty badly, had had the idea two years earlier that the election of either Hoover or Thomas would result in the destruction of the country by foreign nations. He began to make speeches for Roosevelt but was taken to a hospital where, he says, 'I thought everybody was holding me to prevent me from saving the world from destruction.' Another patient, the same one who thought he had poisoned the world with syphilis, kept repeating, 'The world needs me. I must save it.' The cases so far cited appear to indicate that the idea of world destruction is the fulfilment of a wish to destroy, this wish being often due to recognizable motives, and that patients may react to this wish as to any other destructive wish with feelings of guilt and various defense mechanisms including reaction-formations. We are led therefore to a conclusion which, once stated, sounds like a truism, namely, that the idea of world destruction represents a wish to destroy.

If this conclusion is correct it should be possible in some cases to trace the steps by which the object of the destructive impulse comes to be the whole world rather than some individual, since it is usual for impulses of hatred to be directed primarily against individual human beings. This hypothesis, that the hatred which culminates in the wish to destroy the world is originally directed toward individuals, finds confirmation in some of the cases already cited. For instance, the boy who was angry at being put in the tub displaced his anger from the doctors first to the hospital and then to the whole world. The young man who wanted to be let out

threatened grave consequences first to Dr. B. and myself and then to the whole world. Such a displacement of hatred from individuals to whole groups is, of course, one of the most common types of defense seen in all types of neuroses as well as in normal individuals. A patient of mine told me he wished all women in the world were dead and went on to say, 'I think of all the millions and millions of tons of dirt that make up the earth.' In other words, he thought of the earth as a lifeless mass of dirt. The precipitating incident responsible for this mood was that a particular woman had refused to have intercourse with him. The original wish that all women were dead turned out to be a conscious wish to murder the woman in question.

I might add that in the original memoirs of Schreber, the man whose world destruction delusion was analyzed by Freud, the same progression of ideas can be followed in the visions which preceded and accompanied the idea of world destruction, beginning with the deaths of the patient's wife and of his chief persecutor Dr. Flechsig, and extending successively to German Protestants, then to all Germans, then to all Aryan races, then to the whole human race and finally involved the destruction even of the constellations.

It is not difficult to see what the patient gains by this displacement of murder wishes from individuals to the whole world. To face a murder wish against an actual person whom one might conceivably injure in actuality and who might retaliate is far more difficult than to face a wish to injure a whole community or the whole world. To destroy the whole world instead of a single person sounds like a tremendous increase in sadism, but in actuality is a successful defense against actual aggressive impulses, since it is impossible to do any actual harm to the world. To withdraw one's libido from the world does not seriously injure the world, but often severely impairs one's own ability to deal with the world. To destroy the world is therefore an act of self-injury. To express it differently, the sadism displaced from its original

source has actually been turned inward despite the illusion that it is turned outward.

This leads one to the rather close relationship of world destruction fantasies to other manifestations of sadism turned inward, namely, suicidal impulses and delusions of impending death. Of the eleven patients on whom the present paper is based, the idea of the patient's own death played a prominent rôle in eight. Of these, six had definite delusions that they were about to die, while two had fantasies of suicide. One patient had anxiety attacks in which he feared the world was coming to an end and others in which he was momentarily convinced he was going to die or was already dead. This patient, a thirteen-year-old boy, also had a dream in which the two ideas occurred simultaneously. He described this dream as follows: 'I dreamed once that the world was coming to an end and that everyone was going to be shot and leave the old folks to face it alone.' I asked, 'What old folks?' He said, 'All the parents. The children were all going to be shot. I felt the bullet in my neck. It hurt me and I was frightened and woke up.' In this dream the destruction of the world is a thinly disguised wish to destroy the parents. They were going 'to face it alone'. Some of this aggression came out directly in his associations. He was angry with his father for beating him. But a part of the aggression is displaced, not only to the world, but to himself. He dreams that he is to be killed and actually feels the bullet.

Another patient, the one who said that had he only touched a plate he could have prevented the end of the world, showed an interesting series of fantasies on successive days. A few days later he complained of the treatment, threatened suicide, and kept repeating over and over the words, 'I'm doomed'. The following day he said, 'I am a condemned man and everyone who speaks to me is condemned. Everyone who comes into this building is condemned. Condemned to hell's fire forever.' The day following he kept telling other patients that they were condemned. That evening he said, 'All around

here is hell. The whole world is condemned.' It was the day after this that he told me, 'The whole world is going to pieces in ten minutes. I could have saved it, but I didn't do it. I'm going to die and when I die the whole world is going to pieces.'

This succession of thoughts is interesting. He begins with a threat of suicide and then develops the conviction that he is doomed. He then extends this doom first to those who talk to him, then to everyone who enters the building and finally to the whole world. I may mention that a few days later he gave expression to the underlying destructive drive by an actual self-injury. He deliberately burned his own hands with cigarette ends, and explained it by saying, 'I can't help it'. It would appear that among the objects from whom sadism may be displaced to the world an important rôle is played by the patient himself, though presumably even this self-destructive drive was originally directed toward external objects.

It should not be forgotten that the idea of destroying the world is a suicidal fantasy in a literal sense also, since the patient is himself a part of the world; but this suicide is like that of Samson who destroyed the temple of the Philistines at the same time that he killed himself so that he did not die alone. In many patients this idea that they are going to die too, remains a part of the world destruction fantasy. In eight of my cases the idea that the patient himself would die when the world came to an end was expressed in so many words and the same idea seemed implied in two of the others. The idea of remaining alive despite the end of the world appears to be a step which comparatively few, at least of my patients, took. It was not stated definitely by any of the latter group though it was hinted at by one patient, a very seclusive paranoid patient who refused to give any clear details. It will be recalled that during part of Schreber's psychosis he definitely believed that the world had been destroyed but that he remained alive as the only real human being. In the early part of Schreber's psychosis he also

believed he would die. He made several suicidal attempts, and asked for the poison intended for him. He even describes a memory of an experience in which he felt himself dying during this part of his illness.

Some patients appear to identify their own death directly with the end of the world. For example, one of my patients said, 'I know you folks are afraid. You are afraid I will burn up and then you will all die.' Once this same patient, who believed he was God, became angry and threw himself on the floor with the words, 'It is the end of the world!' Another patient, the same one who expressed strong feelings of guilt over his wish to destroy the world, shouted, 'My body is falling apart. The whole world will die out. I have died, doctor. Bury me. I can't talk. I choke. The whole world will die!' In both these patients their own death and the destruction of the world are brought out as if they were equivalent concepts. In these patients at least, there appears to exist an identification of the whole world with their own bodies. When they die the world dies. Such an identification cannot be without importance and it may offer a clue to a deeper understanding of the dynamics of world destruction.

To summarize what has been said so far, I believe we may conclude that the idea of world destruction is the fulfilment of a destructive wish which was originally directed toward individual objects. As an expression of aggression turned away from objects, it has a motivation similar to that of suicidal impulses, an idea which is confirmed by the frequent coëxistence of the two phenomena clinically.

Whether the wish to destroy the world is primary and the wish to destroy one's self is secondary, or whether the suicidal impulse precedes the wish to destroy the world is a question which may not have a general answer, and which in any case cannot be answered from the data which I have presented. It would probably require detailed analytic work with patients in the incipient stages of a psychosis.

I would like to add a few words on the pleasure gain which the patient derives from the idea of world destruction. It appears to be more pleasant to think of the end of the whole world than of one's own death alone. Misery loves company, and the idea that the world is coming to an end involves the simultaneous gratification of sadistic and of masochistic impulses, that is the gratification of a destructive wish without distinction between the ego and external objects.

Another point of some interest is that despite the prominence of destructive wishes in all my patients, only two made actual suicidal attempts. The majority gratified their destructive impulses in a regressive way by means of wish fulfilling delusions, namely that they were going to die, that the world would come to an end, that they were capable of destroying the world, etc. Here we have a regression to infantile magical thinking which believes in the omnipotence of thought. The thought is taken as equivalent to a reality. This regression appears here to have a biological function. It preserves the patient's life. Such excessive destructive impulses can find a realistic gratification only in murder or suicide, suicide being by far the more probable. If the patient is able to gratify these desires magically by a delusion he saves his life, even though he sacrifices his objective relation to reality. This appears to me to be one biological function of the regression to magical thinking. This would fit in with the prominence of magical thinking in obsessional neurosis, which is also characterized by strong sadistic impulses. It is only in the case of destructive impulses, dangerous to life, that a magical gratification is biologically preferable to realistic one.

PROBLEMS OF PSYCHOANALYTIC TECHNIQUE

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III

The First Analytical Steps—Dynamics and Economics of Interpretation

Up to this point we have determined how psychoanalysis operates *in principle:* it demonstrates derivatives of the unconscious as such, and thereby induces a tolerance of the derivatives which become less and less distorted. Gradually it confronts the ego with contents previously warded off and abolishes the division between these isolated contents and the personality as a whole. It allows the warded off instincts to catch up with the development which the ego has passed through in the meantime, changing infantile into adult sexuality, and thus makes possible a well regulated sexual economy. It leads to 'condemnations' of certain instinctual satisfactions by the reasonable ego and, finally, to sublimations. Everything else is incidental.

What are the practical details of this process? What happens after a patient lies on the couch? Here I am tempted to make a digression and to ask another question: should the patient lie down at all? I believe we will do well to yield to such temptations to digress. The advantages of the usual position of the patient, recommended by Freud,[26] are clear: it allows the patient relative relaxation, and makes it easier for him to say unpleasant things because he does not face the analyst; and the analyst himself is saved the discomfort of having to

This paper is the second part of a contribution by Dr. Fenichel to problems of psychoanalytic technique. The remainder will appear in succeeding issues of The QUARTERLY.

[26] Freud: *Further Recommendations in the Technique of Psychoanalysis.* Coll. Papers, II. London: Hogarth Press, 1933. p. 354.

control his own facial expressions. To these advantages is opposed a disadvantage: the observance of a prescribed 'ceremonial' produces a 'magical' impression and may be misinterpreted by the patient in this sense. We know, however, that in general the advantages preponderate but that we can and must be *elastic* in the application of all technical rules. Everything is permissible, if only one knows why. Not external measures, but the management of resistance and transference is the criterion for estimating whether a procedure is analysis or not. There may be one of two reasons for deviating from the usual position. First, the patient may not want to lie down. As a rule, we do not yield to resistances but analyze them. However, there are exceptions to this rule: if a patient has an agorophobia, we will not require him before the beginning of the analysis to ignore his fear and go out into the street. We must estimate to what degree the patient can endure opposing his phobic restrictions. If we have the impression that a patient *cannot* lie down and would rather forego the analysis than do so, we will allow him to sit. We must then take care that he is not permitted to observe the phobic avoidance strictly in a new sense of security; we must insist that this subject be talked about. Secondly, the patient may be too eager to lie down. The magical character of lying down can be utilized for resistance in such a way that analysis and life become isolated from one another and the patient vaguely feels that what he says while lying down is no longer valid when he stands up. Some patients, otherwise timid, are impudent on the couch. So an analysis may apparently run smoothly, but actually only on the condition that the patient is lying down. The exclusive use of this position may nullify the effectiveness it usually has. Just as some patients go to the toilet before or after the analytic hour or perform some other specific act which separates the hour from the rest of their lives, so the external situation of analysis serves the same purpose for others. The analyst must *interpret* the resistance with reference to this purpose. In many cases

we support the interpretation by having the patient sit down and so demonstrate to him how differently he feels in the new situation. Often the information that analysis can also be conducted with the patient in a sitting position suffices to make the patient realize that to him 'analysis' and 'reality' are different and an actual change of position is not necessary. Freud [27] has pointed out how important it is to frustrate the attempt by some patients to divide the visit to the analyst into 'official' and 'unofficial' parts by saying a few more words to the analyst after the termination of the hour. This attempt should be frustrated, according to Freud, by drawing the 'unofficial' remarks into the next 'official' hour. But just as often the opposite measure is useful in eliminating the resistance of isolation. The continuation, even for a moment, of an interpretation or a conversation begun in the hour, when the patient is no longer lying down, is often a very effective demonstration that analysis concerns the individual's entire life even when he does not happen to be lying on a couch.

We now return to our question: what happens after a patient lies down? He begins to talk. As we know, he can say whatever he wants. If he has symptoms, he will in most cases begin with them, otherwise with present difficulties that trouble him. If he has neither of these, he will begin with trifles of the moment that occupied him just as the hour began. Symptoms and present difficulties predominate among the subjects chosen because the patient is aware that he consults the analyst for a definite *purpose*. If he does too much talking about his symptoms and never gets away from the conscious description of his difficulties, then that is a resistance which requires special handling. But even aside from this resistance, the fact remains that the 'free associations' of analysands always retain an aspect determined by the conscious awareness of the purpose of the whole analysis. This knowledge, the wish for recovery, is of the greatest importance as a motive for overcoming the resistances. Its significance may

[27] *Loc. cit.*, pp. 359–360.

be observed in cases where it is lacking. In such cases it is necessary, before the analysis, to alienate from the rest of the patient's ego the pathological conduct which is not yet felt to be pathological. If a reasonable ego from which such conduct could be alienated is also lacking, then analysis is in principle impossible, and a pre-analytic pedagogical treatment is required to establish such a reasonable ego. In practice, however, such an ego is never completely lacking, and initial analytic steps to extend gradually the ego domain are made possible by utilizing the residual ego. This seems to me the only possibility. I do not understand just what can be meant by a 'surprise attack on the patient in which one gets into direct contact with his id'.

There is undoubtedly also a *pathological* wish for recovery. Nunberg[28] has devoted a paper to it. It consists of the patient's magical hopes: *(a)* he strives for a strengthening of his neurotic equilibrium; *(b)* he hopes to get infantile wish fulfilments from the analysis.

With reference to the former, it may be stated that many people develop toward others no real object relationships, but use other people to solve or alleviate their intrapsychic conflicts. For example: the defiant man leads another person to do him an injustice so that he can make use of the injustice as a weapon against his superego; other people, for the same reason, strive for proofs of being loved, in order to cite the forgiveness therein implied in an 'appeal' from condemnation by their superego; the liar calls the hearer of his lies to witness in an intrapsychic conflict between remembering and a tendency to repress. Sometimes love is used to satisfy the most varied narcissistic needs and to relieve intrapsychic tensions.[29] For such purposes the analyst too can be used by the

[28] Nunberg, Herman: *Über den Genesungswunsch.* Int. Ztschr. f. Psa., XI, 1925. pp. 179–193.

[29] Incidentally, insofar as such narcissistic requirements play a part in love, the latter is *disordered;* when Jekels and Bergler (*Übertragung und Liebe.* Imago, XX, 1934. pp. 5–31.) describe precisely these narcissistic needs as the essence of love reactions, they are dealing with the *pathology* and not the psychology of love.

patient. He does not want from the analysis a liberation from the crutches of his former neurotic equilibrium. He expects stronger crutches.

The patient's hope to get from the analysis infantile wish fulfilment is exemplified by the expectation that in 'getting well' an early need for revenge will at last find satisfaction. Here belong the 'exceptions' described by Freud,[30] who expect that the special consideration from fate which they believe they deserve, will begin with their 'getting well'. In particular, one finds women who expect that after the analysis they will at last possess a penis.

Such pathological wishes for recovery can be favorable to the analysis as motives for overcoming resistances, *but only to a certain degree.* At some point the *irrational* element which they contain will become a resistance. Reik [31] once expressed the opinion that the utterance of tabooed words can alone have a curative effect through belief in the omnipotence of words. But the analyst is *not* omnipotent. If he relies on a belief in omnipotence as a curative factor, he has fallen into the Charybdis of 'floating' in emotional experiences without the aid of his reasoning power, and this must ultimately have its unfortunate consequences.

What is true of the pathological wish for recovery is equally true of the so called positive transference. Incidentally, one must doubt whether a division of transference forms into 'positive' and 'negative' is accurate. The transference forms occurring in neurotics are distinguished by their ambivalence; that is, they are as a rule at the same time positive and negative, or at least they can easily turn from the one form into the other. Insofar as they express resistance in analysis, we may call both of them 'irrational transference'. If, on the other hand, we should wish to designate as 'rational' transference the 'aim-inhibited positive transference' suitable for

[30] Freud: *Some Character Types Met With in Psycho-Analytic Work.* Coll. Papers, IV. London: Hogarth Press, 1934. pp. 319–323.

[31] Reik, Theodor: *Surprise and the Analyst.* New York: E. P. Dutton & Co., 1937.

analysis, that would be self-contradictory; for transference is bound up with the fact that a person does not react rationally to the influences of the outer world but reads past situations into them. So the positive transference, like the pathological wish for recovery, may be very welcome during long periods of an analysis as a motive for overcoming resistances; but *insofar as it is transference,* the impulses belong to infantile objects, and therefore a time must come when these same transference impulses become resistances, and their true relationship must be demonstrated to the patient. We shall return to this.

Pathological conceptions of getting well may in some cases function as resistance from the beginning of an analysis. This is the case when a defense which is directed against a forbidden impulse is also directed against the conception of recovery, because recovery means gratification of the forbidden impulse. Many 'negative therapeutic reactions' result from the fact that the patient prefers his *status quo,* full of displeasure as it is, as the lesser evil, as better than a change to health which is perceived as a feared instinct satisfaction.

To return to our main theme, the wish for recovery and the knowledge of the real purpose of the analysis always impart to the free associations of the patient the most *general* sort of purposeful tendency. Apart from that, we seek by means of the fundamental rule to eliminate purposeful tendencies as much as possible. However, I should like to interpolate here the opinion that it is questionable whether it is good to charge all prospective patients with the observance of the fundamental rule as early as the preliminary consultation or the beginning of the first analytic session. While we still do not know the patient, it is possible that we are imposing such a task upon a person with a brooding mania, in which case we make our work very difficult. Therefore I usually say at first merely that the patient must tell me a great deal about himself before I can tell him anything, and it would not be sensible if he did not try to be entirely honest in his communications. An

opportunity can then soon be found to make the rest clear in a manner suited to the individual case.

I should like to yield to the temptation to digress again, and before the discussion of the theory of free association, to consider other questions concerning the preliminary consultation. The rule that the patient should not make vital decisions during the analysis, I usually present only after I know the patient better and can be sure that he does not unconsciously hear such an admonition as a parental prohibition or even as a castration threat. To be sure, it is good practice to present this rule as soon as possible in the case of persons with a tendency to 'acting out', since it would be too late after a certain vital question has already become the representative of a definite unconscious conflict.

Another question is how to construe the rule that 'analytic treatment should be carried through, as far as is possible, in a state of abstinence'. I believe that in respect to this rule no misunderstanding is possible.[32] A *symptom* is a *substitute* for something repressed, and when in place of it another substitute a little more pleasant beckons to the patient, he gladly accepts it and is content with it. We are reminded of the account by Glover,[33] already cited, concerning 'artificial compulsion neuroses, hysterias, and paranoias'. This holds true particularly for the transference. If the analysis becomes a *game* of any sort, if the daily hour is in itself some satisfaction for the patient, then he will only hold on to this bit of satisfaction and nothing drives him further. Therefore the analyst must not offer his patients any *transference satisfactions.* ('Playing along' with the transference actions of the patients is contraindicated for other reasons, too. More about that later.) The fulfilment of what the patient longs for most in the analysis serves as a resistance to further analysis and therefore must be refused him.

[32] Freud: *Turnings in the Ways of Psycho-Analytic Therapy.* Coll. Papers, II. London: Hogarth Press, 1933. pp. 396 ff.

[33] Glover, Edward: *The Therapeutic Effect of Inexact Interpretation.* Int. J. Psa., XII, 1931. pp. 397–411.

In the case of patients who 'act out', it sometimes occurs that such insufficient 'provisional satisfactions' burst forth outside the frame of the analysis. If we can demonstrate to the patient the resistance character of such actions, all is well; if not, we will under certain circumstances invoke the 'rule of abstinence' in this situation, too, and advise him to abstain from the actions in question. In the same way we must induce the phobic patient at a certain point in the analysis to subject himself to the displeasure of the phobic situation. In this respect perverts and addicts present a special problem, because their symptoms are pleasureful in themselves and are already a portion of 'substitute satisfaction'; and when certain 'secondary gains' are present, we find the same situation in the case of ordinary neurotic symptoms. We can in these cases advise the patient to abstain from those activities that are detrimental to the analysis but we should know that this advice cannot be of much benefit at first, because the patient for the time being knows no other forms of pleasure. If he could give up his symptoms upon a mere command, he would not need analysis.

However, we also hear another interpretation of the 'rule of abstinence' than the one I have presented. There are analysts who want completely to forbid their patients any sexual activity, or at least sexual activity under certain circumstances, such as extramarital or premarital intercourse. What do they really expect from such an attitude? Do they believe they can silence a physiological function with a prohibition? And do they consider it desirable to eliminate and to surround with a prohibiting atmosphere the very function which analysis seeks to restore, and to free from prohibitions, and supervise in its advancing liberation? Do they believe that they are furthering the analysis when they renew the sexual prohibitions of parents and other educators which have driven the patient into his neurosis? We hear of such prohibiting advice especially against masturbation. But unfortunately the analyst cannot do away with an obstacle to his work so con-

veniently. If masturbation disturbs the analysis, we have to analyze the connection between masturbation and analysis.

We return to our earlier question: what do we expect from the fundamental rule? In human beings there are always many unconscious impulses which wish to express themselves, pushing constantly towards consciousness and towards motility, and others, the defensive tendencies of the ego, acting in the opposite direction. In this play of forces present stimuli continually interfere. None of these stimuli remains quite without connection with the unconscious impulses that are constantly in search of 'representatives'. The response to an indifferent outer stimulus can therefore, according to the circumstances, become either a *derivative* of an unconscious impulse, or in case it is recognized in that rôle, once more the object of a defense.[34] These connections between present reality and unconscious impulses are particularly strong in the neurotic. The neurotic is characterized precisely by never reacting to outer stimuli appropriately, but always according to definite patterns of reaction acquired in the course of his childhood. If the actions, impulses, and associations of human beings are fed always both by present realities and the past, in the case of the neurotic the past always predominates because, not differentiating sufficiently between the two, he always misunderstands the present in the sense of his unsolved past, and that includes both his present instinctual impulses as well as present external reality.

Into the conglomeration of past and present, of derivatives that want to express themselves, and of the reality principle that determines what is now allowed to be expressed, the *ego* as representative of reality is constantly stepping in with definite ideas of *purpose*. What one wants to say or do right now, suppresses all impulses that do not belong to this purpose. (The absence of this suppression, determined by the purpose of the moment, is a specific problem in the psychology of mania.) The ego is continually selecting, in a modifying way,

[34] Freud: *The Unconscious*. Coll. Papers, IV. London: Hogarth Press, 1934. pp. 122 ff.

from among numerous impulses constantly emerging. Fuchs [35] rightly points out that we should speak not of a 'dream work', but rather of a 'work of the waking state'; for the psychic events that take place in accordance with the primary process run their course relatively automatically, but the ego constantly intervenes with a special expenditure of energy in order to subject these psychic events to the secondary process.

By observance of the fundamental rule we attempt to eliminate as much as possible the regulating activity of the ego described above. Then the 'derivatives' of the unconscious must become more clearly recognizable as such. At the same time we endeavor to exclude special outer stimuli, which could influence the patient's impulses in a particular direction or effect an undesired selection among them. When the analyst, by means of irritating remarks, *provokes* a display of emotion in the patient, we may not speak of this emotional display as 'transference'; at least we shall not be able to demonstrate as such the portion of transference which must of course be present in such an affect too. When, for example, we are striving to demonstrate to the patient in their true function, certain character traits of his which serve as resistance, and for this purpose we imitate him, we are likely thereby to injure his narcissism. If then he becomes angry, we have not thus 'liberated his negative transference', but have simply made him angry.

What do we see then when a patient sincerely strives to exclude his 'purposive tendencies' by following the fundamental rule of free association? We can thus eliminate, to be sure, very many interferences of the ego, but not the strongest ones. The 'resistances' remain. Precisely those defenses against instinct which were pathogenetic, are inaccessible to the conscious will, and often enough the patient is not aware that they are effective. What we then catch sight of is the expression of a conflict, the alternate approaching

[35] Fuchs, S. H. *Zum Stand der heutigen Biologie.* Imago, XXII, 1936. pp. 210–241.

and receding of the unconscious impulse. The patient knows nothing of the fact that what he is saying is the expression of such a conflict.

Thus we see that the 'resistance' remains effective even when the fundamental rule is applied. What is resistance? We could say it is the force that has caused the pathogenic defense. But does not this answer oversimplify the matter? Freud [36] indeed has said that there are five kinds of resistance. But the division into these five kinds of resistance was, as Freud himself emphasized, quite unsystematic. In principle we can, I believe, adhere to the equating of 'resistance' with 'resistance of defense' or, as Freud says, 'resistance of repression'.

Let us with this in mind examine the four other kinds of resistance:

(1) The *resistances due to secondary gains* are, it is true, something else. They are often extensive and decisive for the technique of many analyses; but after all they are also a concern of the ego and are more likely to be accessible to the conscious will.

(2) Transference resistance is not to be contrasted with 'resistance of repression'. It is true that transference actions frequently look like impulses of the id, but the fact that such impulses are resistance is due to the destruction of the context to which they belong, to the incorrect place at which they appear, and to the compromise character which they receive through the intervention of the defending ego.

(3) The *superego resistance,* I believe, in the same way does not proceed from the superego, but from the ego, which tries to yield to a prompting of the superego. There are manifold conflicts between ego and superego. We cannot at all explain, for instance, the phenomena of compulsion neurosis without assuming a 'double countercathexis'—one against the id and one against the superego. The resistance activities proceeding from the superego are fundamentally only a variety of resistance of repression.

[36] Freud: *The Problem of Anxiety.* New York: W. W. Norton & Co., 1936. pp. 138–139.

(4) There remains the so called *resistance of the id,* of which we shall speak separately.

We see then in free associations a to-and-fro struggle between instinct derivatives and defenses, wherein the topics of the symptoms, present difficulties and everyday trifles predominate owing to the awareness of a general purpose which has not been excluded. A patient compared the beginning of each analytic hour with the releasing of a compass needle which till then has been held at rest. The magnetic needle does not at once point toward the north, but swings back and forth until it finally takes the proper direction. Here there are two primary possibilities of disturbance: the magnetic needle may not come to rest in a specific direction but keep on swinging; or without swinging, it may seem to come to rest too rapidly, too directly, or too exactly. When it does not come to rest, the associations become spread out, the patient talks much, but approaches no unconscious impulse. No common denominator of his remarks shows itself. That is a definite resistance, which must be demonstrated as such. It can be brought about in two ways: *(a)* Negatively, through a special fear. Reich recognized that a constant 'superficiality' of talk, anchored in the character, corresponds to a 'fear of psychic depths' which is identical with a fear of falling, a fear of the depths of one's own body and of one's own excitement. *(b)* Positively, 'superficial' talk affords a special libidinal gain or an aggressive one (for example, the patient wants to annoy the analyst). If nothing is said for a rather long time either about the neurosis or about daily life, then something is wrong. Often this kind of resistance assumes the form of the patient's not hitting at all upon the idea that those everyday things which really matter must *also* be talked about. Sometimes a demonstration of 'association' by the analyst is of help here. In certain cases, nothing is said in the analysis about daily life for the reason that daily life is *really* without any interest for the patient. There are persons who live so much in their fantasies that they do not even notice everyday things. In such cases it is our task to make the patient

conscious of the *defense* inherent in such an attitude toward fantasy and reality, but we must not follow him in such behavior nor, without paying any attention to reality, fantasy along with him about the father's penis in the mother's body. When the magnetic needle sets itself 'too exactly', the patient is so filled with the ultimate purpose of the analysis that he can and will speak only with respect to this purpose, only 'according to a program'. This form of resistance we see particularly in compulsion neurotics and other character types who operate chiefly with the kind of defense called isolation. They do not succeed in giving their thoughts free play without control.

We already see how particularly important it is for analysis to take into consideration the *general* types of defense, since their effectiveness, if not attacked, *destroys* the value of all the work otherwise accomplished.

How do our first interventions usually look and what do we expect from them theoretically? From the very first words that we pronounce in the analysis we do nothing else than 'demonstrate derivatives as such', and at first the *most superficial ones.* Usually we first endeavor to do away with general isolations by showing the patient *connections* between events, feelings, and intentional attitudes, connections which he had previously not noticed, although they were obvious. (If they are not so obvious that even the unprepared patient must notice them with 'surprise' as a result of a simple demonstration, then we will remain silent about them and save up their demonstration until later). We show *connections* between *ways of behavior,* which are calculated first to make the patient *curious.* In all this, we always strive to demonstrate what we understand by 'psychic reality', with which we wish to work. Furthermore, we demonstrate, wherever it is possible, that the patient in reality actively brings about things which he seems to experience passively. Moreover, we try to bribe him by showing him, whenever an opportunity presents itself, how analysis can be *beneficial* to him. Much more can be said about all this. We shall begin with the demonstration of the

patient's own responsibility in bringing about experiences that seem merely to happen to him.

The patient tries to let himself go completely. Everything now comes 'of itself'. He does not notice that it is he *himself* who interferes with the course of his impulses. The purpose of analysis is *in general* to make the unconscious accessible to the ego, that is, to help the ego to understand that something it has passively experienced is really actively brought about by a part of itself. The aphorism, 'where id was, there shall ego be',[37] means that the ownership of that which happens out of one's own unconscious should be restored to the ego. Applied to the symptoms themselves, this notion is certainly incredible to the patient at the beginning of analysis. Therefore, attempts to demonstrate this in relation to the symptoms are contra-indicated (we shall talk about 'too deep interpretations' later on), and it cannot be emphasized enough that not only conversion symptoms which the patient considers somatogenic, but also the melancholy of a depression (in contrast to ordinary normal sadness) or great anxiety are experienced as *completely alien to the ego,* as something that storms its way over the ego which is itself completely passive in the situation. Thus at the start a 'secret activity' can be demonstrated in what seems to be 'passively experienced', only if we attempt to point out at the most superficial points how the patient is interfering with his own impulses and activities. If we consider once more how instinctual impulses that press towards discharge are in conflict with defensive impulses that prevent the discharge, we see that in analysis we work always and exclusively on the latter, the defensive impulses.

'You are in a state of resistance', is an interpretation which has often been subjected to ridicule. When this interpretation is presented in a tone which attempts to throw upon the patient at the start the responsibility for his difficulties, then it is really ridiculous. But in another tone it is a correct

[37] Freud: *New Introductory Lectures on Psychoanalysis.* New York: W. W. Norton and Co., Inc., 1933. p. 112.

interpretation, and in principle, it seems to me the first correct interpretation to be given. It brings about a change in the patient's attention and makes known to him something about himself that he did not know before. In every conflict of repression the unconscious ego is to be sure unconscious, but nevertheless it is more easily accessible than the warded off instinct. Sometimes 'substituted instinctual impulses' which seem to be more superficially situated become evident first; but these substitute impulses have two aspects, and the defense aspect of their 'substitutive' character is more easily accessible than their nature as representatives of the original unconscious. We shall return to this problem.

Against all this an objection can be raised. The unconscious impulse which pushes toward consciousness and motility is of course our ally, the defensive ego our enemy. That is true. But we are in the situation of a commander whose troops are separated from his allies by the enemy's front. In order to unite our forces with those of our ally, the warded off instinct, we must first break through to him, and for that we need another ally accessible to us, the reasonable ego, which must be detached from the defensive ego. To remain in the metaphor, we must first disintegrate the enemy's ranks with propaganda and win over large portions of his forces.

Premature attempts to reach this ally, the instinct which seeks discharge, must fail. The compulsion neurotic, for example, has regressed to the anal-sadistic level in a flight from the claims of his genital œdipus complex. The question has been asked: should we not in practice gain an advantage from this knowledge of ours and begin at once with the treatment of the actual pathogenic conflict, the genital œdipus complex? An analogous train of thought is apparently followed by all those analysts who expect success from 'bombarding' the patient with 'deep' interpretations, that is, from telling as quickly as possible what they themselves have recognized as a pathogenic conflict. This is the case not only with Stekel and his followers, but also with those analysts who, by means of the primal-scene interpretation of a child's game, hope to

establish a reasonable ego when none was previously present. 'Contact' with the patient can really be brought about in this way under certain circumstances, that is, when this deep interpretation acts as a seduction; but then it can also miscarry like a seduction and evoke reinforced defensive measures. At any rate, in the case of the compulsion neurotic we cannot begin with discussion or treatment of the genital conflicts for the reason that these conflicts are for the time being no longer present, but are replaced by the anal-sadistic conflicts. We cannot begin with the depths without having previously dealt with the surface. And in principle what holds for genitality and anality in the compulsion neurotic holds similarly for instinct and defense against instinct in every analysis.

In a seminar an analyst once described a case, the analysis of which seemed at a standstill. The patient could no longer speak at all in the analytic hour because he was full of aggressions. The analyst could clearly see that this tendency toward aggression, remaining from childhood in an undischarged form, was now directed against him in the transference. But he could make no progress with it. 'What shall I do?' he asked. 'For weeks I have been telling him in every hour that he wants to kill me; but he does not accept the interpretation.' Such an interpretation in that sort of situation *augments* the anxiety and with it the ego's defense instead of diminishing it. The correct interpretation would have been: 'You cannot talk because you are *afraid* that thoughts and impulses could come to you which would be directed against me.'

A still more flagrant case of a similar sort was an analysis that made no progress because of the patient's defense against his aggressive tendencies which had become acute. The analyst reported: 'The patient asks me again and again how long this must go on in this way, since the treatment apparently is making no progress, what can be the result, and the like. I keep telling him that he wants to torment and kill me with these endless questions, but there is no change.' In this case not only has the aggression been interpreted instead of the defense against aggression, but besides this it has been over-

looked that the patient's questions were *actually justified.* When a treatment costing precious time and money comes to a standstill, the patient has indeed a right to ask the physician for information about the situation, and not until this right is admitted and the answer is given can the transference nature of the patient's affect be demonstrated—and this at first only from the defense aspect.

In symptoms, in substitute affects and in irrational ways of behaving, this struggle between a more accessible defense side and a less accessible instinct side is evident. We see it in all its stages. Only when it is so far manifest that it can be disclosed in conscious and preconscious phenomena, can we make it accessible. Sometimes the defense struggle coming to light in the analytic material is clearly evident to the patient from the very beginning; then we can dispense with the 'first act' of the interpretation, the 'isolation from the observing ego'. But in the face of rigid, affectively shut in, or passively submissive, or generally inelastic persons, there is no sense in talking about the contents of their defense conflicts; in these cases the 'isolation' of the defense conflict must precede. In other cases it is often important, under certain circumstances even decisive, to recognize that the same struggle which can be vividly detected by the patient at one point, is effective also at some other point, where to the patient there appears to be only an inflexible manner of behavior. In such cases the same conflict which we can interpret with relative ease at the point where it is still active, must also, after isolation from the observing ego, be interpreted in its rigid remainders.

The following case is an example of such a constellation. A poet, critical of society, in analysis because of oral and anal character difficulties, has developed in his artistic activity an original and extremely effective style. His irony is of the type of a 'stubborn obedience', carried out by taking literally the utterances and pretexts which he wishes to criticize, and by means of naïveté and simplicity exposing deceitful complications. His success with this is particularly impressive in his anti-religious activities. He is to be sure aware of this method

of his through subsequent reflection, but he has no suspicion that in other instances he continually makes use of the same mechanism of 'controversy by means of stubborn obedience' against his own superego; that in situations where he considers himself 'obedient', where he really considers himself 'stupid' in his 'simplicity', he is unconsciously aggressive and is rebelling against the 'deceitful complexity' of the world of adults. This was already developed when he started in school as a boy of six and had to sit next to the hot iron stove. The heat was so unpleasant that he could not pay attention and merely kept thinking: 'When it's so hot, I can't understand anything'. He never complained in any other way than through this inhibition of learning, and he thought that it had to be so hot in school, or else the teacher would not have seated him in that place, and if he could not understand anything, his stupidity was to blame. In the analysis it was necessary that the mechanism which he used actively and consciously for artistic purposes be shown to him also at those points where, unknown to him, it had crystallized in certain characterological ways of behaving.

To 'thaw out' such 'frozen' conflicts between instinct and defense, so that in place of an automatic way of acting a conflict is once more experienced, is indeed a principal task of analysis. For at many points the original pathogenic conflict has led to some chronic ego alteration, which takes care of the matter once and for all and spares the individual subsequent more acute types of defense requiring more energy expenditure.

Should our opinion therefore be that every compulsive character must in the course of a psychoanalysis go through acute attacks of anxiety? No. He need not necessarily, I should think, actually experience these anxiety attacks in their full severity; but he need not experience them thus only because correct dosage in analysis can avoid this. In my opinion it is *fundamental* that he really pass through the anxiety which he had previously warded off by means of his compulsive

character. But the restoration of mobility at those points where there has been rigidity must not take place with a shock, for analysis also requires *gradualness* of mobilization. Anxiety attacks in the case of former compulsion neurotics can indeed occur in the course of analysis, and they need not be feared. But we are distrustful of too great a preference on the part of analysts for such 'eruptions'. We must not provoke 'breakdowns' and must not seriously injure the patient's narcissism by continued aping of his characteristics.

With such conditions the Charybdis of too much acting is again approached. There are indeed two opposite types of defense: flight to the theatrical, to magic, to direct libidinal activity (mostly feminine or masochistic); and 'flight to health', away from fantasies to sober reality and finally to words divorced from affects (though later again cathected with affect). When a patient is too 'calm' in analysis, one cannot at first know whether a true lack of affect is present or the suppression of a particularly strong affect. This is just as with a dream fragment devoid of affect, about which one cannot at first tell whether it is relatively insignificant or whether the expression of its significance is merely prevented by a countercathexis. Two locomotives under full steam working against each other with equal power travel just as little as two locomotives not under steam at all. But just as the coal consumption makes clear which of these alternatives is true, so also does the energy consumption reveal the true state of affairs with the patient. Calmness as defense fatigues the patient, or its defensive nature can be noted in the rigidity of the musculature or of certain portions of the musculature. For example, a patient may report that his bowel movements are quite in order in such a way that one must take this report as a sign of unsolved anal-erotic conflicts just as much as the report that he is continually constipated or suffers from diarrhœa. In such a case the associations likewise come so characteristically 'in order' that there is no doubt but that they must first be brought into disorder so that later on real order can be attained.

At this point a slight digression may be interposed. Alexander [38] has described as 'neurotic character', a person who is continually impelled by his unsolved childhood conflicts toward unsuitable actions in reality. Alexander asserted that this type of neurotic character can be influenced more successfully by analysis than can a symptomatic neurotic because the latter has regressed from the alloplastic to the autoplastic mode of reaction, and after successful analysis must first acquire the courage which is necessary for progressing to actions in real life. This necessity is absent in the case of the neurotic character who is always acting out anyway. This point of view I should like directly to contradict. The pseudo-alloplastic reactivity of the neurotic character can be changed into a healthy alloplasticity only by being first temporarily transformed into a 'neurotic autoplasticity' and then treated analytically like an ordinary symptom neurosis. Internal conflicts which have been crystallized in spurious object relationships must first be transformed back again to internal conflicts and as such find their solution, before normal object relationships can appear in their place.

What we said about the evacuation of the bowels is also true in regard to sexual potency. The report of a patient that he is capable of complete sexual satisfaction must therefore be sceptically regarded, just like the assertion that there exist neuroses with complete orgastic potency, which theoretically there cannot be. Such cases have been repeatedly discussed in detail in case seminars, and every time the relative insufficiency of the orgasm has come to light.

It is relatively easy to see where things must be 'thawed out', that is, what the current analytic task is. It is much more difficult to carry out this task, which means to find those points where at the moment the system is shaky, where the neurotic defense is weak, and thus the places and times at which the struggle between instinct and defense has remained most alive. In this task it is always a question of reversing

[38] Alexander, Franz: *Der neurotische Charakter.* Int. Ztschr. f. Psa., XIV, 1928. pp. 26–44.

displacements, abolishing isolations, or guiding traces of affect to their proper relationships.

The 'topographical' formula for interpretation was that it should 'make the unconscious conscious'. The correct guessing and naming of the unconscious meanings of a neurotic symptom can sometimes cause its disappearance, but sometimes not. That result depends specifically upon whether such designation of the unconscious meaning succeeds in really altering something dynamically at the point of the instinctual conflict. Therefore the more correct dynamic formula is that we must 'remove the resistances'. From interpretation analysis was evolved resistance analysis.

That it is not enough to *name* the conflicts becomes particularly clear in a frequently recurring situation: the patient talks, and indeed not without emotion, but with feeling adequate to his really important conflicts. For example, a transference situation is being discussed and at the same time there takes place in the way the patient behaves a *duplicate of what is being spoken about, in wordless action on a different level.* How the patient receives the interpretation and reacts to it, what feelings he experiences during the conversation, must then in turn be put into words. If the interpretation of a symptom is especially impressive when it comes about in connection with a new edition of the symptom in the transference, it is quite particularly so when, during the interpretation of the transference phenomenon, the analyst can point out that in the patient's behavior, to which he had given no thought at all, the very same thing is present *once more.*

The possibility of speaking about something without being aware of how real it is, is the basis for a certain type of resistance. There are patients who consciously or unconsciously formulate words without noticing, or indeed with the unconscious purpose of *not* noticing, that behind these words are to be found the *dynamic forces,* which to be sure we can influence only by words. In such a case we must not *talk* with the patient about his conflicts, but should demonstrate to him how he makes use of talking. Other patients try to

flee from one instinctual attitude into the opposite one; then again we should not ask which is the more genuine. We should not ask, for example, whether we should 'interpret first the heterosexuality or the homosexuality'. What must be interpreted is *the oscillation between the two positions as defense.*

From the vantage point of this insight into the dynamics of interpretation, several generally known rules can be commented upon here:

(a) 'One should always start the interpretation at the surface.' How otherwise? In what other way could we penetrate to the depths than by beginning at the surface? Analysis must always go on in the layers accessible to the ego at the moment. When an interpretation has no effect, one often asks: 'How could I have interpreted more deeply?' But often the question should more correctly be put: 'How could I have interpreted more superficially?' The deep conflicts also have their representatives in the trifles of everyday life, and it is there that the patient can really become aware of their effectiveness. If the daily trifles do not come to discussion, then a special resistance is present—probably an isolation of the analysis from real life.

(b) 'The patient determines the subject matter of the analytic hour.' This rule is a corollary of that other one, that we must always work with 'living reality'. What does not interest a patient cannot be forced upon him. For example, the premature attempt of little Hans' father to interpret his œdipus complex had to fail, because just then his anal erotism was the subject of the moment.[39] But the word 'interest' requires an explanation. The patient 'determines the subject matter' not always by what he says, but frequently also by what he does *not* talk about, or by *how* he speaks, or what he does. At this point there is very frequently a misunderstanding of the attempt to formulate a 'more systematic technique'. We cannot provide the analyst with a plan of

[39] Freud: *A Phobia in a Five-Year-Old Boy.* Coll. Papers, III. London: Hogarth Press, 1933. p. 207.

procedure applicable to all cases. But we believe that many things not spontaneously put into speech by the patients are shown involuntarily by other indications, and that it is then the task of the analyst to speak about them. That is not 'activity' of any special kind on the part of the analyst, but is dynamic interpretation. For we must operate at that point where the affect is actually situated at the moment; it must be added that the patient does not know this point and we must first *seek out* the places where the affect is situated.

(c) 'Interpretation of resistance precedes interpretation of content.' This rule again follows automatically from our dynamic insight. An effective interpretation of content succeeds because of a consonance between external auditory perceptions and internally experienced impulses, such a consonance enabling the impulse to break through. A consonance is not possible when it is blocked by a wall of resistance which makes the recognition of the impulse unfeasible. In this case we must first remove the wall. It becomes particularly important to realize this in dealing with long lasting so called 'character resistances'. When a compulsion neurotic does not react to interpretations of content, one cannot console oneself with Freud's simile,[40] which in other connections is justified, that in the launching of a ship from its moorings one cable at a time has to be released, and the journey does not begin until after the last cable is clear. On the contrary, in analysis in general, it is of prime importance that the cables be released in the *correct sequence,* and first the crucial ones. But this leads us already to the economic aspects of interpretation.

(d) 'We should avoid too deep and too superficial interpretations.' When is an interpretation too deep? When the patient cannot recognize its correctness by experiencing the impulse in question. When so called too deep interpretations, that is, the naming of unconscious processes which the patient cannot feel within himself, nevertheless show results, such results can be nothing else than 'unspecific' ones; in other words,

[40] Freud: *The Interpretation of Dreams.* New York: The Macmillan Co., 1923.

results that are independent of whether the interpretation is 'correct' and that come about through non-analytic changes in the dynamics of the patient.[41] They can, for example, be results of a seduction which lies in the fact that what is otherwise taboo is being spoken about. In favorable cases such seduction can lead to diminution of anxiety and therewith to the production of less distorted derivatives; in unfavorable cases it can lead to aggravation of the fear of instinct and strengthening of the defense. But even in the most favorable case such a decrease of anxiety, which rests only on the fact that the analyst also did something taboo, can last only as long as the analyst keeps doing this and, as in hypnosis, as long as the 'rapport' remains unclouded. *By no means* is such an 'interpretation' an interpretation in the true analytic sense, which is a real confrontation of the experiencing ego with something which it had previously warded off.

When is an interpretation 'too superficial'? When, because of the analyst's fear of affects, it in some way plays along with the patient's efforts to cover up his affects. Especially the neglect of sufficiently definite transference interpretations can bring a bitter retribution. While a transference is developing, there are present much clearer and more easily recognized derivatives of the true context to which the transference behavior belongs; when a more 'intensive' transference has developed and there is a closer interweaving of the impulses with the person of the analyst, the real context to which these impulses belong has become less recognizable to the patient. We cannot evade resistances; if one wishes to operate, one has to cut and must not be afraid of blood. By the omission of mature interpretations at least as much can be spoiled as by the presenting of immature ones.

The paradoxical rule that one should drop an interpretation which the patient accepts and insist upon one which he refuses, sounds ingenious, but it is certainly fundamentally wrong. Of course there is a way of apparently accepting inter-

[41] *Cf.* Glover, Edward: *The Therapeutic Effect of Inexact Interpretation.* Int. J. Psa., XII, 1931. Pp. 397–411.

pretations which is resistance, but a real assent of the patient is our goal. And of course there is a way of 'refusing' interpretations with words, and still the behavior or following associations betray that the interpretations were nevertheless accepted. A true 'no' on the part of the patient is a proof that the interpretation was wrong, and if not wrong in content, then not presented correctly from the point of view of dynamics or economics.

Besides the dynamic side, the economic side of interpretation must also be discussed. We must work not only at the point of actual instinctual conflicts, but at the point of the *most important* current instinctual conflicts. It is the point of the most important conflicts *at the moment*. For this reason the *sequence* in which the interpretations are presented is of such great importance.

In the psychic realm, as is well known, overdetermination is the rule: in every psychic act every unconscious tendency is represented. Therefore it is of concern to the analyst which of the unconscious tendencies he should pick out. That is what Rado meant when he used to say, 'Interpretation is an economic process'. The correctness of this view in practice has been made clear to us especially by Reich [42] in his writings on technique. There is no doubt that through interpretation incorrect in the economic sense, we are threatened with 'chaotic situations'. However, we must not forget two things: *(1)* not all 'chaotic situations' need be the results of faulty analysis. Spontaneous 'chaotic situations' also exist; for example, there are certain character disturbances which are marked by the disorder and unreliability of their extremely ambivalent object relationships and by the alternating appearance of instinctual tendencies and defensive attitudes from all possible stages of development. These disturbances could not be otherwise diagnosed than as 'spontaneous chaotic situations', and are mostly ego disturbances of traumatic origin. *(2)* An enormous rôle is played in the psychological domain

[42] Reich, Wilhelm: *Charakteranalyse*. Vienna, 1933 (published by the author).

by something similar to what is known in geology as 'faulting'. Imponderables of life at the present, which represent now an instinct temptation, now a reinforcement of anxiety, keep bringing about at each moment varying displacements of the 'psychic layers'. Interpretation takes place *not* exactly in reversed historical sequence. Nevertheless the sequence of the interpretations remains economically determined; otherwise, interpretations presented in an arbritary order result in arbitrary, that is, irregular dynamic alterations: instinct becomes defense, defense becomes instinct, and we have a confusion of everything.

My meaning will perhaps become clearer through another metaphor: one cannot see the forest for the trees. In case seminars we often hear correct interpretations of details, but the inexperienced analyst does not know what the situation of the entire person is—just which of his observations is 'important', because it returns in various forms and reflects a structure, and what, on the other hand, is 'unimportant', because it is the chance formation of a libidinal situation of the moment.

Freud [43] once warned us against attempting too often in the course of an analysis to sketch a picture of the case. We must always be ready to let ourselves be led by the patient to something quite different from what we had expected. However, we can also go too far in condemning the formulation of case summaries during treatment. In my opinion such case formulations can be of two types: one which at the beginning helps tremendously, is indeed necessary, and one which is harmful. Specifically, the analyst can make use of the symptomatology, impression of the personality, behavior and also childhood memories in order to formulate for himself a dynamic and economic collective picture of the structure of the case, merely an orientation system out of which further problems then follow. That type of formulation is *necessary*. With such a framework one listens further with freely floating attention, and with it one orients oneself in that oscillation to intelligent understanding previously described. Of course

[43] Freud: *Recommendations for Physicians on the Psycho-Analytic Method of Treatment*. Coll. Papers, II. pp. 326–327.

the framework is altered according to new experiences but, since it is merely a *framework,* by and large it remains standing and becomes gradually more definite. It contains genetic elements, too, because we always experience a psychic structure as a precipitate of its developmental history. However, after all that has been said, it does *not* include the constructions of details of infantile events deduced from the first screen memories. It is such constructions, necessary in their own good time, which constitute the other, hindering type of case formulations, and this type is often set up because of a worry of the analyst that he 'does not understand the case'. But if an analyst does not understand the details of his patient's childhood from the beginning, that is nothing to worry about. We really need not trouble ourselves so actively about the patient's childhood. It is still actively present anyhow in the behavior of the patient today; otherwise it would not interest us at all. If only we put the present in order correctly and understand it, we shall thereby make new impulses possible for the patient, until the childhood material comes of itself.

On the economic side belongs the *dosage* of interpretations. It is a task of the physician to have the therapeutic process involve as little pain to the patient as is possible. In particular, the 'shattering of a narcissistic armor' is painful. We shall return to the subject of 'gradualness' in the discussion of 'working through'.

Alexander [44] expressed the opinion recently that resistances should, if possible, be attacked only by the naming of that against which they are directed. This technique cannot always be correct. To be sure, defense and instinct are in fact so bound up with each other that we sometimes cannot name one without at the same time working on the other. However, such a designation of what is warded off is indeed frequently 'nonsense', because the patient cannot find in himself what has been designated, as long as a resistance prevents its reaching the preconscious. It would be just as nonsensical in such a situation to leave the resistance untreated because

[44] Alexander, Franz: *The Problems of Psychoanalytic Technique.* This QUARTERLY, IV, 1935. p. 600.

then nothing at all would ever be changed. Even as long as nothing else can be said about a resistance than that it is present, it is certainly better to call the patient's attention to it than to leave it unheeded.

The more one knows about the nature, origin, and purpose of a resistance, the better can one understand its acute occurrence and demonstrate it to the patient. Therefore the more *factual* material one knows about the patient, the more easily an analysis is carried out; also, only the knowledge of his history enables us to understand the allusions contained in his associations. Especially in the beginning of an analysis, it is an important task of the analyst to *accumulate* as much factual material as possible from the life of the patient. Perhaps, since my aim is to formulate a theory of technique, I have entered too hurriedly into the dynamics and economics of interpretation, and have therefore neglected to talk about the necessity for this preceding accumulation of material. Every bit of knowledge concerning the past facilitates for us the understanding of the present. As long as a patient tells us facts about his past, we shall gratefully accept them—unless, as sometimes occurs, a particular contra-indication is present, when such talking about the past represents a resistance aiming to prevent us from working with 'living material'.

What has been said about the dynamics and economics of interpretation in general, applies of course also to dream interpretation. Dream interpretations which are wrong from the economic standpoint are not only not accepted, but they make the analysis difficult or spoil it for later on because through such interpretations the patient gets a premature intellectual familiarity with the ideational contents of his unconscious, and the analyst is then in the position of one who has shot off his ammunition before it was possible to hit the mark.

Should dream interpretations be therefore completely avoided as long as the character resistances have not been dissolved? Sometimes that is correct. There are some particular contra-indications against dream interpretations: *(1)* The *isolation* of 'deep' dreams by a more superficial resistance. The dreams deal with very deep lying conflicts of the patient,

of which he cannot yet feel the faintest derivatives in his waking life ('dreams of the unsuspecting'). *(2)* Dream interpretation has taken on too much of a certain transference significance. As an activity it signifies in itself a special libidinal satisfaction for the patient or allays a special anxiety. In this case the unconscious significance of dream interpretation must first be recognized and eliminated, before it can be practiced. But apart from such special contra-indications there is, in my opinion, no reason not to utilize the 'royal road to the unconscious' as much as possible.

We will remember that Freud [45] said that in the use of dream interpretation in practical analysis, two activities must be differentiated: the translation of the manifest dream into the latent dream thoughts, and the utilization for the analysis of what has been found out through the translation. Now it is certainly correct that in this second activity we must let ourselves be governed by the caution which insight into the economic aspect of interpretation prescribes for us. However, one often cannot perform the act of translating beyond a certain point without communicating to the patient what one has already guessed, and this communication is already in itself an 'interpretation'. The two phases of interpretation cannot be strictly separated from each other in practice, and an exaggerated choice by the analyst of what should be interpreted is thereby shown to be impossible. Another circumstance excludes such a possibility. In free association, associations often become understandable through what *follows*. Before this subsequent association has followed, one can therefore not know what to omit from an interpretation.

Especially for the understanding of the present preconscious immediate situation, dreams can often be amply utilized. Another question is how far it is possible to utilize for analysis manifest dream texts even without dream analysis. The observation of character peculiarities and types of defense in the manner in which the distortion takes place in dreams is an important field of investigation and one that is certainly too

[45] Freud: *Bemerkungen zur Theorie und Praxis der Traumdeutung* (1923). Ges. Schr., III. pp. 308–309.

little cultivated as yet. How characteristic, for example, of a person whose nature is marked by a 'flight to reality', is the enormous development of 'secondary elaboration' in his dreams, which at every point produces intelligible connections. Also important in the course of the analysis as a mirror for the changing state of the economic equilibrium between instincts and instinct defenses, is the changing of the mechanisms of distortion in the manifest dream content.[46] On the other hand, I am for various reasons very sceptical of attempts to classify the manifest dreams according to the prevailing instinct groups, to count the representatives in the individual groups and thus to draw graphs.

Should we say that the analyst must always know what he is doing, why he interprets, and what he expects each time from his activity? I should like especially not to be misunderstood in this, for I do not mean to say that we should replace intuition and freely floating attention with exertion of the intellect. What is meant is that, after we have reflected upon it, we should always be able to explain what we are doing, why we interpret, and what we expect each time from our activity.

In conclusion: *how does interpretation work?* We do not want to differentiate at this point between interpretations of resistance and interpretations of instinct, but we ask about the factors common to both cases. The answer in general is this: the attention of the ego is drawn to a 'preconscious derivative'. How does that take place? *(1)* What is to be interpreted is first *isolated* from the experiencing part of the ego. This preliminary task drops out when the patient already has some critical attitude toward that which is to be interpreted. *(2)* The patient's attention is drawn to his own *activity: he himself* has been bringing about that which up to now he has thought he was experiencing passively. *(3)* He comprehends that he had motives for this activity which hitherto he did not know of. *(4)* He comes to note that *at*

[46] *Cf.* French, Thomas M.: *A Clinical Study of Learning in the Course of a Psychoanalytic Treatment.* This QUARTERLY, V, 1936. pp. 148–194.

some other point, too, he harbors something similar, or something that is in some way associatively connected. *(5)* With the help of these observations he becomes able to produce less distorted 'derivatives', and through these the *origin* of his behavior gradually becomes clear.

Why does a patient 'accept' interpretations? *(1)* Because he recognizes as true within himself that which has been interpreted to him. We interpret, as is well known, what is already in the preconscious—and just a *little bit* more—which thereby becomes capable of entering consciousness. *(2)* As a result of the paradoxically designated 'rational transference', that is, because of a positive emotional attitude toward the analyst which induces the patient to take a less sceptical view concerning anything expressed by the analyst. *(3)* As a result of identification with the interpreting analyst. Doubtless the patient essentially imitates the analyst when he now divides his ego into an observing and an experiencing portion and so comes to see the discrepancy between his impulses, determined by his past, and his present reality.

In this section of our discussion about psychoanalytic technique we have attempted, through working out the dynamics and economics of interpretation, to make more concrete what we had set forth in the previous section concerning the essential mode of action of interpretations in general. The abundance of the material to be dealt with caused the discussion to become somewhat tangled. Perhaps before we proceed further we should make what has been said still more concrete and thus again draw the thread of our logic taut. I propose to do this by two means: first, by supplementing from the structural side what has been said concerning dynamics and economics through extending our inquiry to the question of so called ego analysis and id analysis; secondly, by investigating in particular that special case of interpretation which directly constitutes a criterion of analysis: the handling of the transference.

Translated by DAVID BRUNSWICK

To be Continued

SCHOPENHAUER AND FREUD: A COMPARISON

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It has frequently been said, and with some justice, that for his *Weltanschauung* Freud drew inspiration from Schopenhauer; their philosophies have been compared, and numerous analogies between them have been sought and found: the same pessimism on the part of both thinkers, the same despairful vision of the world, of man and of society, the same somber realism which traces human spirituality back to the workings of obscure primitive and instinctual forces.

The celebration of the birth of Schopenhauer (February 22, 1788) has drawn renewed attention to this still insufficiently appreciated philosopher, and provides the opportunity to substantiate the close connection between his philosophy and Freud's, upon which latter a recent volume has just thrown vivid light.[1] We are not here concerned with making a detailed examination of the two systems; such an undertaking would lead us too far afield. We shall confine ourselves to a brief comparison of some of their most important doctrines. We shall speak of their doctrine of life in general, of their theory of æsthetics and of ethics, and of their conception of love.

At first sight the 'general philosophy' of Freud appears to be a faithful reproduction of that of the sage of Frankfort. As is well known, it reduces the world, and life in particular, to an interplay of forces acting in coöperation or, more often, in antagonism to one another. After having, in his original system, contrasted the sexual instincts with the ego instincts, he then distinguishes between the libido (sexual instinct, or eros) and Thanatos (or the instincts of death and destruction).

[1] Dalbiez, Roland: *La Methode Psychanalytique et la Doctrine Freudienne.* Paris: Desclée de Brouwer & Cie., 1936.

Everywhere and always in the world, in the living organism, in its biopsychological activity, in its mental and social life, these two groups of forces manifest themselves and for the most part are set in violent opposition to each other. Man cannot act, cannot seek to realize his desires, cannot enter into contact with his fellow beings, without at the same time giving expression, directly or indirectly, to his erotic and aggressive impulses, and without feeling the repercussions, usually painful, the prohibitions and the penalties, which the group inflicts upon him for the attempts he makes to break his bonds. With all his might the individual strives for happiness, for the satisfaction of his needs, for the avoidance of suffering (pleasure principle). But his moments of happiness are rare and transitory. Suffering threatens him from three directions at once: 'from his own body, doomed to disintegration and dissolution, from the environment, whose physical forces of destruction lie ceaselessly in wait for him, and from society, which constantly impedes the freedom of his movements'.

In a word, Freud reduces the mind, the intelligence, the higher sentiments and the will to the action of instincts and impulses of physical and animal origin. The fundamental psychic phenomenon is the instinct, the impulse *(Trieb),* either individual or in the collective, generic and undifferentiated sense (the id). The conscious ego, with its various intellectual, rational and moral functions, is thus only the product of the differentiation and sublimation of the primitive undifferentiated being—a differentiation which is the result of contact with the physical and social environment.

We know, moreover, that nervous and mental illnesses consist of a crystallization, a fixation, at a period of development prior to moral-social differentiation, or of a regression thereto, or in other words, of a 'dedifferentiation' which may be deep or superficial, transitory or permanent. This conception is a fundamentally dynamic, positive and realistic one; it envisages life as a never ending conflict between the forces of life and death, between the forces of constructiveness, progress and love and those of strife, destruction and disintegration. Under

the sway of the former we yearn for union and communion with a sexual partner or with one of our fellows, we strive to create, to diffuse life and energy, to give out joy, to make things in our own image, the fruit of love and sympathy. Therein lies an enrichment, an advantage for others as for ourselves, a giving of ourselves: we sacrifice ourselves, we dedicate ourselves, we forget ourselves, we give ourselves to another being, to an ideal, to a labor which transcends us. Psychoanalysis speaks here of sacrificial forces and tendencies. Sometimes, on the other hand, acquisitive instincts dominate us; then we seek either to gain objects which we lack, to possess and keep wealth, to rule, to ruin, to destroy other beings, objects, or we submit to being injured, wounded, to dying ourselves—and therein Thanatos, death, reunites with the creative eros. But we are never truly ourselves, we are never free.

What does Schopenhauer say on this subject? Sometimes he considers the world from an objective point of view, as Idea—an aspect which hardly interests us here; sometimes he considers it from its subjective angle, as Will. It is this 'will' of the universe which fundamentally constitutes its essence, its value, its soul. Every volition, every individual act, every effort, aspiration or wish is nothing but the manifestation of this universal will, as physical bodies, material things, represent its objectivation.

But what is this will? It functions in a blind, brutal, instinctive manner. We perceive in it neither consciousness of purpose nor affirmation of self, neither order nor organization, neither a realized plan nor a struggle against external opposition—that is, none of the criteria which one usually attributes to a voluntary act. Schopenhauer endows it only with freedom, but in addition to this he conceives it as impulsive, arbitrary, disordered, violent. All the passions, all the desires, all the Bacchic frenzies of nature have free play. In short, it is will or instinct, the appetite for life, in its simplicity. It is easy to recognize here a confused mixture of eros and Thanatos, of creative and libidinal tendencies, aggressive

and destructive impulses. For the will begets living species, creatures and organisms, as also it does murderous war.

Freud's dualism is here substituted by a complete monism. While the father of psychoanalysis sees the source of evil either in the conflict of the two groups of tendencies or in the triumph of Thanatos, Schopenhauer finds it in life itself. There is here more than merely a shade of difference; this divergence of opinion is translated into a difference of attitude concerning the treatment and cure of the trouble. We shall refer to this again in connection with æsthetics and ethics.

Another contrast which is more apparent than real concerns the problem of freedom, which is completely denied by Freud, whereas the philosopher of Frankfort places it in the world of 'things in themselves', in the world of Will. But how can a force, an activity, which is blind, aimless, disordered and uncurbed be called 'free'? Of what use is freedom which acts without discernment and choice, and engenders only confusion and unhappiness? On the other hand, what shall prevent us from considering as free in themselves both eros and Thanatos whose activities we may observe, but of whose hidden purposes we are ignorant?

Finally we shall consider a final difference closely related to the foregoing. Whereas Schopenhauer believes in a world of noumena, invisible and unknowable, Freud the pure scientist, makes no mention thereof. He does, however, call our attention to the often striking contrast between appearance and reality, between manifest 'content' and latent; and does not his whole diagnostic and therapeutic method consist after all in lifting the 'veil of Maya', as Schopenhauer requires us to do?

Let us now consider the theory of art of these two thinkers. For Freud æsthetic activity is entirely analogous to dream activity. On the one hand, we find again most of the mechanisms which are at work in the elaboration of a dream: displacement, condensation, dramatization, secondary elaboration,

symbolization. We shall return later to the question of symbols: let us remark here only that Schopenhauer makes no connection between æsthetic and dream activity. According to him, the dream is a singular intuition of reality in a chaos resulting from a suspension of rational and critical functions. This is certainly an insufficient interpretation, but one which leaves open the door to various less superficial explanations, the psychoanalytic among them.

On the other hand, the work of art, and likewise the dream (myth, delirium), fulfil biopsychological functions: they are substitutes for reality, compensations for disappointments, disguised realizations of wish. Both originate from a lack of psychic and emotional satisfaction, and are the result of intense unconscious activity; both have a ludic *(ludique)* and cathartic function and are connected to a large extent with sex life. These are indeed characteristics nobody would think of denying.

Let us now examine Schopenhauer's thesis. Art represents to him a kind of liberation from the bonds of necessity and from the constraints of the phenomenal world. Its object is the contemplation of 'pure idea' *(reine Vernunft)*, the first manifestation of the will to live. The artist, like the spectator, completely forgets his dependent and material existence; he rises by his imagination and the intuition of his genius to the object itself, undistorted, in its natural form; he widens and expands its horizon and tries to seize in a unique aperception the image which the will has endeavored to realize. Art, or rather æsthetic vision, consists in penetrating the divine, the eternal, through the veils of the ephemeral and the phenomenal. No longer taking part in the world of the will, the contemplator, the creator, feels himself purified, freed, exhilarated, and refreshed by his view of nature, of the object itself. This state of being is a kind of ecstasy, a sensual pleasure; for the individual, no longer taking part in the world of phenomena, forgets even his own existence and has in consequence no longer any reason for suffering. Fantasy helps to create in itself this state of mind, it helps to exalt and to

clarify the spirit; but the essential thing with the artist is contemplation *(Anschauung)*, the very intuition of the essence of things. Knowledge thus takes precedence over will and action.

There is æsthetic voluptuousness in this description by Schopenhauer; there is a grandeur, an abundance, an inspiration which lifts the philosopher to the level of true poetry. One feels constantly the influence of Plato and Kant, whom, by the way, he quotes freely. Nevertheless the sage of Frankfort expresses here many just and true ideas, and analyzes with force and clearness the state of 'detachment', of spiritualization, of 'æsthetic trance', entered into by the artist and the man of genius. Let us not quibble unduly over certain contradictions and inaccuracies. Let us try above all to perceive its points of contact with the freudian theory.

Evidently artistic creation (and likewise contemplation) presupposes a disinterest in and a renunciation of certain immediate satisfactions (material and intellectual), a relinquishment and abatement of voluntary and instinctive activity. The dream vision and uninhibited play correspond closely to the contemplation of 'pure reality', of Platonic essences and ideas. We can take a further step and compare these ideas with the images and symbols studied by psychoanalysis. One knows that these symbols are objects replacing other objects and thus invested with significance; they are representations calling to mind ideas or emotional states by means of analogy, of unconscious association. They represent primary, hidden, disguised elements. Symbolic thought is a concrete, primitive, simple mode of thinking in generic and collective images endowed with potential affectivity. Here we find a certain resemblance to the 'Platonic pure ideas', a kind of replica of concrete objects and phenomena, born of creative will and contemplated by the artist. However, the latter seem to be more or less abstract essences, removed from material reality, bathing in an ethereal and superior world. The artist, the man of genius, thus inhabits, if one combines the two points of view, two different spheres, invisible and imperceptible to ordinary mortals: the spiritual, immaterial universe of ideas

and the sphere of the personal and collective unconscious (Jung). The two may be reconciled if one considers the former to be a decantation product, purified and sublimated, of the latter.

As far as Freud's ethics are concerned, one must distinguish between his genetic theory of ordinary morality and the morality which he himself sponsors. We shall omit from consideration the former, which is but a more or less precise application of psychoanalysis to the interpretation of social and moral phenomena. As to Freud's ethics, they are undeniably a scientific and intellectual ideal. The only way to escape evils which surround us and lie in wait for us, he says, is to trust in science, in intelligence, in reason. By becoming more and more clearly conscious of obscure and unconscious forces which enslave us, we shall succeed gradually, in a more or less remote future, in knowing and recognizing them, in becoming able to look them in the face and thereby in conquering them. Thus we owe our salvation to a progressive widening of the field of our consciousness, to an intellectual and rational attitude, for it is only through the knowledge, through the comprehension, of a danger that we are successful in meeting it, in conquering fear and the emotions which it creates. The virtuous and wise man is he who knows what is hidden in the shadows of his soul, and whose clairvoyant and fearless gaze paralyzes the evil instincts which are his worst enemies.

Schopenhauer's ethics are the ethics of compassion and disinterestedness. As it is the will which begets all evil, violence, war, injustice, we must leave it behind us, must turn away from the world of phenomena, sacrifice our egos and renounce the realization of our personal wishes. For as soon as one need is gratified, another or rather ten others are born, like the Hydra's heads. Hence one must die, withdraw from concrete and active existence, and give oneself up to a purely passive and contemplative life. Only asceticism, sacrifice, the conquering of desires and passions, can give us true happiness.

More than this, we must atone for all the evils, all the iniquities, committed at every moment. The compassion and love which follow therefrom, redeem us and redeem evil and unhappy humanity. Thus man frees himself from his animality and rises to the region of the pure contemplation of eternal ideas.

At first sight these ethics stand in complete contrast to Freud's. They have an emotional basis, mystic, religious; whereas Freud relies solely upon the purifying power of reason and thought. However, let us be careful not to be misled by appearances. Both Schopenhauer and Freud take their point of departure from a pessimistic view of the world. Both see in the supremacy of our appetites, of our instincts and personal desires, the fundamental cause of our ills. Both seek salvation in the disarming of these lethal and nameless forces which dominate us. And the means which they advocate are not after all so far apart. The knowledge, the insight into ourselves, preached by the father of psychoanalysis; the renouncing of the gratification of our passions and instincts, the contemplation and mystical vision of ideas praised by the philosopher of Frankfort—both lead in the end to the same solution: the abandonment of an active and aggressive attitude in favor of a state of knowledge and contemplation, of a 'spectator' point of view at the same time intellectual and sentimental. Nothing but the predominance of the mind and of pure thought over instinctive animality can make us both better and happier.

In conclusion let us examine Freud's and Schopenhauer's theories of love. The former's is simple and clear and can be expressed in a few words. He is strictly monistic. He recognizes in all the manifestations of love only the brutal, pure or sublime, naked or disguised expression of one and the same force: the sexual instinct. According to him there is a gradual transition between the heat of animals, the sexual orgies of savages, the carnal desire of the average man and

the most sublime poems of Platonic love, the most magnificent permutations of the feeling of tenderness, of passion on the plane of art, and the raptures and voluptuous ecstasies of mystics. All are the expression of the same condition. the same aspiration, the same impulse, the same natural, elemental need. The progress of civilization has been confined to embellishing, sublimating and refining the manifestations of the instinct to which man owes his greatest joys and his profoundest sufferings.

Schopenhauer's attitude is very different. He distinguishes clearly between the generic instinct which he counts among the most elementary manifestations of the will to live, and spiritual love, born of pity for human suffering. While he actively opposes the former, whether as an expression of Will, generally so inauspicious, or as passion and animal instinct, or as the source of life and consequently of new suffering, he exalts and glorifies the latter. This love has nothing in common with the sexual instinct; it is a feeling of sympathy and compassion with others, a wish to relieve them of their troubles, to share these with them. Love, kindness of heart, says the philosopher, transcends and surpasses every other virtue of man. It is this supreme quality, this generosity, which makes for tolerance and tenderness; it urges us to give and to give ourselves; it compensates us for all our miseries and weaknesses. Thus it hallows the pain which is the road to altruism, to sacrifice and to supreme compassion.

His is here a religious and philosophic point of view, rather than a psychological one. Schopenhauer has not sought the genesis of these magnificent sentiments, he has not seen or has not wished to see their origin, their connections. Freud, on the contrary, as a true scientist, has attempted in particular an exploration of the nature and the development of the emotional life, and even if we do not accept all his ideas, we must nevertheless admit that he is right in many respects. It is Schopenhauer, however, who by his lyrical, metaphysical and mystic tendencies beguiles us more; nobody has yet surpassed his altruistic ethics, his glorification of love and pity.

Let us recapitulate. Schopenhauer and Freud agree on many points in their respective systems and one is justified in comparing them. Both lean to a dynamic, energic and pessimistic conception of life. Both attribute our ills to the domination of our animal and egoistic instincts. Both see deliverance and joy in a half æsthetic, half intellectual (even mystical) state of contemplation, of receptivity, of vision of ideas and eternal pure truths, born of the unconscious creator. Both also exalt creative and sublimated love; *amor intellectualis, amor veritatis.* The two thinkers diverge however on certain fundamental points. Schopenhauer, as a true philosopher, believes in a noumenon transcending us, in Platonic pure Idea; not distinguishing between creative and destructive instincts, he condemns them *en bloc* and preaches asceticism, self-denial, forgetfulness of self. The psychologist Freud, on the contrary, makes a concise analysis of psychological phenomena, which he divides into eros and Thanatos, traces æsthetic and ethical activity to its instinctive sources, and, believing in the purifying virtue of reason, makes himself the apostle of a pure intellectualism.

Translated by HENRY ALDEN BUNKER

CONTRIBUTIONS OF PSYCHOANALYSIS TO THE EDUCATION OF THE ADOLESCENT

BY CAROLINE B. ZACHRY (NEW YORK)

It may be wise to indicate in a few words at the outset of this paper the basic concepts of the philosophy of education which it represents. According to this view, the concern of education is with the total development of the individual rather than with some single aspect of it such as, for example, his growth in intellectual proficiency. It is recognized that development proceeds as a whole, although for purposes of discussion this must be considered in its physical, emotional, intellectual, and social aspects, and although the rate of development in each aspect may differ within the individual. It is recognized, further, that development varies widely from person to person. In its concern, therefore, with the development of the whole individual, education should be adapted to meet the needs of each as a unique person.

Since the growing individual must learn to adjust himself to society, it is accepted as the fundamental purpose of education to help him in this process. This does not, of course, necessarily mean that he must learn to accept society as he finds it, but that he must face it as it is and adjust himself to it in order to be able to participate in satisfying ways and to be able perhaps to change it.

With such a concept of the individual with whom it is concerned and of its responsibility toward that individual, the processes of education logically place emphasis upon the child's own present experience and upon his past experiences as these influence the present. Its processes are based on the belief that the child learns best to deal with life through experience in dealing with it and through vicarious experience which helps him to understand his own; that he learns best when the learning fulfils a conscious purpose. Discipline

is that of life itself, which the child is helped to face in so far as he is equipped to do so; overprotection from life, as well as artificial disciplinary methods, is avoided.

Thus education as here conceived is concerned with the study of the individual in society and takes as its task to help him in development of social competence.

There are several reasons why the period of adolescence is emphasized in this paper as one whose problems of education need special attention and study. The writer is now engaged in directing the Study of Adolescents which is conducted as one phase of the work of the Commission on the Secondary School Curriculum, of the Progressive Education Association. Life histories of whole school classes of so called normal adolescents have been compiled in this study. Although the material is necessarily uneven, since some communities were able to permit more extensive and more thorough investigation than others, in most instances there are included health histories, body build pictures, and the findings of physical examinations (together with the comments the student made during this process) and of Rorschach and other tests, as well as data regarding the school and the sociological background. The communities in which the schools exist were studied by anthropologists.

This project was undertaken, first, in recognition of the fact that the adolescent stands in great need of understanding by the adults who are attempting to help him since at this period he is passing through the most profound transition of his life. He is moving from childhood to adulthood, and this means that he is going through radical changes in all aspects of his development—physiological, emotional, social, and intellectual.

It was undertaken, secondly, because society has given less attention to the needs of youth at this period than at earlier stages of development, particularly in its planning for education. Being fairly new, the nursery school was organized in the light of recent psychological knowledge; it had no barriers of tradition to break down but could base its curriculum on

the needs of young children. To some degree the elementary school, too, has been conducted in the light of understanding of the child. The curriculum of the secondary school, however, was handed down from the university, its main emphasis to prepare the student for higher learning, without serious thought as to whether this preparation would meet his future needs, to say nothing of his present. Even when secondary education became available to a much more diversified group than during its early years, this goal persisted; and for those who could not continue their studies the secondary school tried to supply a dilute substitute for the university. Since the curriculum is directed mainly toward training of the intellect, the adolescent is subject to a great deal of material and treatment which have little significance for him, and also he is offered little help in meeting his more basic needs in ways that are socially suitable.

Not only in the school but in its general attitude toward him, society subjects the adolescent to undue conflict. One of his major problems is to establish his adulthood, but society permits him to achieve this only if his doing so meets its needs at the given time. During a period of war, for instance, adults permit and indeed encourage the adolescent to assume the responsibilities of a grown person in order that their war may be fought; but in a time of depression they force the adolescent to remain in a state of childhood because if he took his place among them he would constitute a social and economic threat.

To be sure the adolescent whose early life has been emotionally rich and reasonably well guided feels less conflict in school and society. It probably is safe to say, however, that no individual goes through this period without conflict. Probably it is safe to say also that it is fortunate that there should be some conflicts, arising both from within the individual and from without, for it is through dealing with them that the young person finally establishes himself in competence and responsibility. But obviously it is the duty of the school to help him in dealing with them rather than to add to them!

This task of the school is a particularly difficult and necessary one since adults in our society generally do not give any special assistance to young people in their approach to adulthood as is done in primitive societies through ceremonies such as the pubic rites.

Having awakened to the necessity of studying young people during this phase of their development in order better to plan their progress, education is ready for an approach that will give insight into the dynamics of behavior. On the basis of their observations of classroom behavior, educators are dissatisfied with the explanations offered by educational psychology and they are turning to psychoanalysis. There are three areas particularly in which education needs assistance from psychoanalysis.

I

The contribution of psychoanalysis to the education of the adolescent which I would put first is its help to educators in understanding better the dynamics of classroom behavior. Psychoanalysis reëmphasizes the psychiatric view of behavior as symptomatic. It has pointed out how primitive urges are manifested in a complex society, how the individual adjusts his biological needs to such a society. It has shown the effects of the ways in which primitive urges have been dealt with in the family. It has shown that the individual is motivated by unconscious purposes unknown to him.

This concept of the dynamics of behavior is a significant contribution because, in order to accomplish its purpose of helping the individual in his social adjustment, education must be able to look at the present behavior of the adolescent and, recognizing it as symptomatic, realize more clearly what it is that the young person is struggling to express, what are his fundamental needs, and come to a better understanding of the lacks in his early experience which are leading to his way of behaving in his high school and college days.

The school is the only enlightened and organized institution which has opportunity to see so much as it may of the

child but it is often too blind to avail itself of the opportunity or to recognize the problems that are confronting youth. During this period the individual is seeking a design for living and he is turning to adults outside the family for counsel and guidance. He needs a great deal of individual help, a great deal of support, even when his adjustment is good or relatively so.

The psychoanalytic concept of personality development gives aid to educators for observing the young person in the classroom, on the playground, in the lunchroom, in extracurricular activities and in organizations with his friends, to appreciate his conflicts, his needs and aspirations—gives them an understanding based on his symptomatic behavior, but one that can be tested by reference, as need arises, to psychoanalytic technique itself and by other approaches which have been derived from this technique. Thus it is possible for psychoanalytically trained observers of young people to understand their individual personality constellations more thoroughly, and to plan their education in the light of their total personalities—not merely in terms of their intellectual needs for the next academic step, but in such a way as to meet physiological, social, emotional, and intellectual needs in their total life adjustment.

In the Study of Adolescents we place great emphasis upon the potential contribution to education of observation of this kind, checked with individual case histories. Observing great numbers of high school and college students in this way also gives us a clue to what, for lack of a better term, we speak of as the conflicts normal to youth, such conflicts as we may hope can be adequately worked out in a group situation such as the classroom, under careful educational guidance. It further gives us opportunity to note behavior which is indicative of deeper emotional disturbance and to determine what specific individual help is needed by adolescents showing these deeper disturbances. These observations will, it is hoped, help educators to know when the individual needs more intensive guidance and help than can be given in the classroom or

informally by the teacher, and should lead to some conclusion as to the responsibility of educators for providing that guidance itself or for directing him to other agencies that are able to give it to him. It is difficult to distinguish between the normal conflicts of this stage of development and persisting neurotic conflicts. Yet it is the educator who is in a position to see both and who may guide the youth through normal conflict and guide toward therapeutic help the individual whose conflict is so great that disaster lies ahead.

Psychoanalysis may help education in the use of another facet of this approach to understanding of the adolescent and that is by the study of creative materials which the young person produces. Through his writing, his painting, even through his creative endeavor in science and mechanics, the adolescent expresses his conflicts and gives us a hint of the kind of solution he is trying to reach. Through experimental study of these materials, psychoanalytically trained individuals can hope better to be able to interpret the problems of youth. The Study of Adolescents has filed with each of its case histories copies of written work and of painting, photographs of stage sets and other bits of construction which have been produced by each individual, and the analytically trained members of the staff have attempted to understand these products, relying heavily in their interpretations upon psychoanalysts.

II

If we succeed in learning how to study behavior and personality development, through observing behavior and through analysis of creative work, we have a basis for planning individualized education to meet the needs of a particular adolescent, and this comes close to guidance in its best sense. Education of this sort would help a group of adolescents in solving their common problem of making a design for living, of being inducted into adult society. Also, as has already been suggested, it would allow for individual conferences with members of the classroom group. Such an education, to be

sure, would be set up in a far better way than now seems feasible.

And we should still for obvious reasons have a number of children in each classroom who need special help, who would be referred to someone more expert than the teacher for special guidance. It is in this area of guidance that psychoanalysis has its next large contribution to make to the education of the adolescent. Most of us are familiar with the contribution of analysis to the work of child guidance clinics generally. Part of this contribution has been that of interpreting the case material or the case histories. This skill obviously is essential to guidance work. Also analytic training contributes to interview technique, to insight into mechanisms, and ability to handle transference.

The so called guidance expert carries a threefold responsibility within any secondary school or college. In the first place, he has the responsibility of working with the teachers to set up a constructive emotional environment for all the young people in the school or college. In doing this he will have to confer with teachers from time to time and give them guidance in relation to particular young people who are turning to the teachers for help. Second, his is the job of conferring with those adolescents whose problems are too severe to be taken care of by the classroom teachers. Third, his job is to deal with those adolescents whose problems are so severe that they need to be referred for psychotherapy and to pave the way for therapy.

Throughout the country, people without analytic training or any other very thorough psychological training are doing guidance work disastrously; yet the exigency of the situation makes it essential that people in schools should work with those students who present particularly difficult problems. Even if clinical help outside of school were available, it would not always meet educational situations. The question of whether such students should be treated on a superficial, short-term basis, or whether they should be referred for deep therapy ought to be decided in terms of a real understanding

of their problems. We should decide it on the basis of whether or not the youngster has a real neurotic difficulty so deep seated that it can be helped only through thoroughgoing psychotherapy, or whether he is meeting a crisis due to the usual adolescent conflict somewhat exaggerated by environmental problems. Unfortunately, however, the decision is not made on such an intelligent basis. It is made rather in terms of time and cost and the availability of expert help.

The short-term guidance case requires a great deal of skill. It ought to be handled by a person who has had experience in working over a longer time with difficult problems. In other words, such work should be done by people with a maximum of training. Yet the opposite is true: this type of guidance work is frequently assigned to people who have the least possible equipment for it.

An effort is now under way to arrange for personal analysis for people undertaking to do short-term guidance work, not with the idea that they will become analysts, but in order to insure their better adjustment, a greater ability to deal with their personal relationships, and a greater insight into the problems of adolescence, in order that they may distinguish between those problems which they may hope to handle on a guidance basis and those which should be referred to a well trained analyst. Through the Study of Adolescents, we are making available several hundred case histories of young people for those who plan to work in this field. Through these histories we hope to be able to indicate the main areas of conflict in the adolescent.

III

The third way in which psychoanalysis is making a contribution to the education of adolescents is through the analysis of adolescents. Analysis at this stage is of itself a process closely related to education, and from it too the analyst of adolescents gains new knowledge of the period of adolescence which may contribute to the understanding of classroom behavior.

The technique of analyzing the adolescent must differ very

widely from that used for the analysis either of a child or of an adult. One of the adolescent's greatest problems is to bridge the gap between childhood and adulthood, and in attempting to do this, he frequently withdraws from adults, making himself quite inaccessible to them; in his behavior he tries to assert his own manhood. He is very ambivalent, shifting rapidly from great self-assertion to infantile dependency. In the normal process of growing up, he turns to adults outside of the home as his ego ideals. Of his own volition he frequently turns to them for advice, using them as parent substitutes and depending to a large extent on their counsel. The analyst of the adolescent has to be prepared to play this rôle. Dependency on grown persons is normal and necessary behavior for the adolescent and it is therefore essential that the analyst play a much more active rôle than with an adult, being ready with advice and warning, and even to take a very positive and active step to prevent a reality situation that would be devastating to the adolescent. At the same time that he is playing this rôle, the analyst has to be constantly aware of the adolescent's need to assume more and more responsibility for himself as well as of his tendency to regress in the face of each new emergency. To play this active rôle, and at the same time guard against giving too much direction and accepting too much dependence, requires of the analyst a great deal of skill.

Like the child, the adolescent is usually brought to an analyst by his parents who pay for his analytic treatment. In the normal course of events parents of adolescents are ambivalent in their attitude toward the fact that their child is growing up, and even if they are well adjusted and have insight, they feel pangs of jealousy toward those adults who gain the confidence and the admiration of their children. Yet the analyst of the adolescent must speed up this weaning process and play the rôle of the intermediary adult. He must therefore deal with the problem of the parent as well.

Since the adolescent is analyzed only by consent of his parents, since it may be that only they, and not he, are aware

that he has a serious problem, and since they are paying the bill, he can be as irresponsible in relation to his analysis as a small child. The analyst must, therefore, during a preparatory period help the adolescent to become aware of his problem and bring him to assume responsibility for his analysis in so far as he can.

On certain occasions the adolescent brings to the analyst conflicts arising not from past experience but from his desire for new life situations which he sees ahead; for he is learning a new way of life. He is asking adults for a design for living in a social order which is trying to use him as a pawn rather than being concerned with his development. In helping him with these conflicts the analyst is using a distinctly educational process.

Thus in the analysis of the adolescent, education and therapy are closely related. Again the important implication of this close relationship is that analysis can make a rich contribution to education. It has already been pointed out that through its underlying concept of personality development psychoanalysis is giving to education greater understanding of the individual. Special knowledge of the crucial period of adolescence can be contributed by those working intensively with young persons who are in this stage of development. In thus broadening the educator's understanding of the person whom he teaches, analysis may contribute to the adaptation of educational and guidance processes to the developmental needs of the adolescent. Thus careful research in analysis, particularly of adolescents—presenting the findings of the analytic situation and of intensive studies of the individual, and indicating their significance for the so called normal young person—has an enormous contribution to make to education.

PSYCHOANALYSIS AND SOMATIC DYSFUNCTION

In a preliminary note announcing this title as a department of THE QUARTERLY,[1] attention was called to the magnitude of the problem created by psychosomatic illness in present day morbidity and incapacity as well as in mortality.

Dr. Weiss [2] writes:

> 'There is little need to emphasize the importance of hypertension. According to the statistics of the Metropolitan Life Insurance Company [3] every other individual in the United States past the age of fifty years dies of cardiovascular-renal disease. From other sources [4] we have evidence that probably half of these deaths are due to "essential" hypertension, that is, that almost one-quarter of all people past the age of fifty years die of the effects of hypertension on one or another of the vital organs. Thus essential hypertension becomes the greatest problem of middle adult life, not even excepting cancer.[5]
>
> 'America is rapidly becoming populated by people of advancing years. For example in 1900 it was estimated that twenty per cent of the population fell in the age group forty to sixty, while in 1950 it is estimated that thirty per cent of the population will fall into this age group. This is the period when hypertension is most likely to manifest itself and to become the most important factor in the development of heart, blood vessel and kidney disease.
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> 'Since so much chronic disabling disease is found in the

[1] This QUARTERLY, Vol. VII, No. 4, 1938. pp. 589–90.

[2] Weiss, Edward: *Recent advances in the pathogenesis and treatment of hypertension.* Psychosom. Med., I, 1939.

[3] Dublin, L. I., and Lotka, A. J.: *Twenty-five years of health progress.* New York: Metrop. Life Ins. Co., 1937. p. 227.

[4] Fahr, G.: *Hypertension heart.* Am. J. M. Sc., CLXXV, 1928. p. 453.

[5] Hedley, O. F.: *Study of 450 fatal cases of heart disease occurring in Washington, D. C., hospitals during 1932, with special reference to etiology, race and sex.* Pub. Health Rep., L, 1935. p. 1127.

population on relief and since hypertension is one of the most important factors in the determination of this increasing chronic disability, hypertension is in reality a most important contributing factor to this undeveloped aspect of social security.'

Alexander, Saul, Menninger, Wolfe, Dunbar, and others have demonstrated that emotional factors are critical in this illness and that psychoanalysis has a contribution to make to this problem. A discussion of this by internists is to be found in the Symposium on Hypertension in the forthcoming first number of Psychosomatic Medicine, which also points the way to further understanding of the physiological mechanisms involved.

In the recent meeting of the American Association for the Advancement of Science, there was a symposium on Mental Health in the Section on Medical Sciences. Dr. C. Rufus Rorem, a leading discussant of this symposium made the statement: *'Hospital costs in America could be reduced by more attention to emotional factors in physical illness.* If the stay of patients were reduced on the average by two days (either through fewer admissions or earlier discharges) the public would be saved *$100,000,000* annually.' [6] Most analysts have had the experience of saving patients hospitalization time.

The present agitation concerning compulsory health insurance measures in this country creates an increasing awareness of the somatic disorders in which the psychic component is the determining one. Attention is being turned more and more to the available techniques for diagnosis and treatment of the psychic factor in illness. Great Britain on the basis of some twenty-seven years of experience with compulsory health insurance has called particular attention to psychosomatic problems. Dr. James L. Halliday, Regional Health Officer, Department of Health for Scotland, for more than twenty years, has written an article commenting on the increase of

[6] Rorem, C. Rufus: *A discussion of the advance contributions to a symposium on mental health.* Section on Medical Sciences, A.A.A.S. Winter Meeting, 1938, Richmond, Virginia: Session III, Economic Aspects.

psychosomatic illnesses in Great Britain during this period. In a letter to the British Medical Journal, published under the heading Social Pathology, he discusses the question: 'Is our nation becoming more or less healthy?' He writes:

> 'We must not forget that this assertion of improving health is really an inference based on an assumption, the assumption being that the needs of living men and women are exactly comparable to the needs of livestock—namely, suitable food, shelter, air, light, and physical exercise. In the past all "public health" measures and most "social" ones have been based on this essentially veterinary assumption . . . improvement in national livestock health has been effected therefore—at least in part—by a growing knowledge of the nature of these needs and by the application of measures directed against environmental factors which frustrate or deny the fulfillment of these basic animal needs.'
>
> In spite of all this, however, he finds evidence of a marked increase 'in chronic and recurring neurotic illnesses, as well as in many examples of organic sickness labelled by such terms as anæmia, rheumatism, gastritis, peptic ulcer, bronchitis, etc. [psychosomatic illnesses]. . . . In other words, a community in which basic psychological needs are frustrated slowly falls sick, disintegrates, and decays.'

In an article, The Rising Incidence of Psychosomatic Illness,[7] he notes that the major increase in neurotic and psychosomatic illness is in the younger age group, whereas one might expect the contrary since this group has been better nourished and suffered less economic hardship than any other age group in the community. In conclusion he says:

> 'The question, "Is the nation becoming less healthy?" can no longer be answered with a vigorous and self-satisfied negative. The indices suggest the possibility of a very different answer. Failure to appreciate the deeper meaning of "health" and the absence of action against environmental factors (including social measures) which frustrate the basic psychological needs of a community will, on this second assumption, result in further disintegration.'

[7] Brit. Med. J., II, 1938. pp. 11–22.

The latest report of the British Health Services [8] is interesting in this respect:

> 'In May 1936 the General Medical Council, as part of a general scheme for a reorganisation of the medical curriculum, passed a resolution giving psychology a defined place in it. . . . This will enable general practitioners to acquire some knowledge of the psycho-neuroses which will be of far greater value, as the British Medical Association Committee on Medical Education pointed out, than a knowledge of the psychoses. . . . To encourage advanced study, Diplomas in Psychological Medicine were instituted after the War. They are awarded by the University of London and by other licensing bodies. The Diploma of the University of London has recently been revised and now covers a study of mental retardation, delinquency and the psycho-neuroses. A much more thorough training based on a study of the psycho-neuroses and of the technique of psycho-therapy is carried out by the British Psycho-Analytical Society . . .'

One may wonder how long it will be before this country which has prided itself on better attention to psychiatric training in medical education and practice than that given in Great Britain, will arrive at similar conclusions.

The foregoing material is interesting rather as emphasizing a problem particularly deserving of our attention as analysts than as a contribution to the problem itself. It is urgently hoped that readers who are able to make brief comments or to offer clinical material which has a bearing on the rôle of the psychoanalyst in the treatment of somatic disorders will submit them for publication here.

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[8] *Report of the British Health Services. A survey of the existing Health Services in Great Britain with proposals for future development.* London: P E P, 1937, p. 354.

BOOK REVIEWS

PAPERS ON PSYCHO-ANALYSIS. By Ernest Jones. Fourth Edition. Baltimore: Wm. Wood and Co., 1938. 643 pp.

The new edition of Jones' well-known Papers omits twenty papers (which we regret) and adds twelve new ones, by which the discussion of the most recent clinical as well as theoretical problems of psychoanalysis are introduced into the book. The author himself characterizes his work with the following words: The present book 'began life twenty-six years ago as a modest exposition of Professor Freud's theories, and has since become a slow moving picture of the development of psychoanalysis as seen through selected contributions made by a particular writer in this field.' This characterization of the significance of this book is absolutely valid but it is insufficient. The person of the 'particular worker' and his rôle in the development of the whole science give the book a special importance. That he has been interested in all issues and problems of psychoanalytic science, and that he has made decisive contributions to most of them, makes it possible for this book to serve as a textbook of psychoanalysis and as a guide for the study of the history of the general development of psychoanalysis.

The inexperienced reader will profit from reading the book in a manner different from the experienced analyst. The former can use it as a textbook because of the excellent assortment of its contributions. It is divided in sections of 'general papers', consisting of ten papers written during the years from 1910 to 1936, 'papers on dreams', with four contributions from the years 1909 to 1921, eleven 'clinical papers', from 1910 to 1929, and seven 'papers on child-study', from 1913 to 1935. Of particular interest are the early papers, which the book contains, replete with formulations and solutions of important problems, a fact often overlooked or forgotten by younger students of psychoanalysis.

The experienced reader is above all impressed with Jones' important rôle in psychoanalysis. The papers on symbolism, the origin and structure of the superego, on anal-erotic character traits, and on jealousy, remain the standard papers of psychoanalysis on the respective subjects. We must admire the manner in which the

theoretical papers, just as the clinical ones, always keep in touch with clinical reality and resist the temptation of speculation.

For contributions to psychoanalysis made during recent years, the statement that Jones makes in his preface is valid: 'Further additions to our knowledge of psychoanalysis have come for the greater part from investigation of the ego.' The well-known contributions of Jones to that part of analytic research in Fear, Guilt and Hate, in The Early Development of Female Sexuality and The Phallic Phase are included in this volume. Every analyst, including those who do not agree with all the statements and points of view expressed by Jones in these papers, must consider them as very inspiring and stimulating contributions to our science.

Jones' 'Papers' have always been a standard work of psychoanalytic literature. The new edition makes this fact still more evident.

OTTO FENICHEL (LOS ANGELES)

PROCEEDINGS OF THE FOURTH CONFERENCE ON PSYCHIATRIC EDUCATION. New York: The National Committee for Mental Hygiene, Inc., 1938. 345 pp.

This volume of nearly three hundred and fifty pages presents the views on psychiatric teaching of nearly thirty outstanding American psychiatrists. It is a report of the conference on that subject held at the Johns Hopkins Hospital in April, 1936. The methods and content of the psychiatric teaching in a dozen leading medical schools are presented. The larger portion of the volume is devoted to the views of Adolf Meyer as they are embodied in the teaching curriculum at Phipps, in a summary of Meyer's philosophy of psychiatry and medicine, and in a detailed outline of his concepts of biology in terms of ergasiology, and of psychiatry in terms of ergasiatry.

A main theme of the book is a plea for the abandonment of dichotomous mind-body concepts in favor of the concept of the organism as a whole, which, mostly through the efforts of Meyer, has so greatly advanced psychiatric thinking in this country. Occasionally however there is still a tone in the report which gives an impression of wishing to be sure that psychiatry is accepted as a part of medicine. This probably is due to a certain uneasiness in psychiatry which comes from the feeling that it does not have the same type of etiological grasp of its data that the other medical

sciences have. As Gregg points out, psychiatry is still groping. That was one of the reasons for this conference. '. . . right through medicine people are beginning to see that you haven't finished with disease when you have described the infecting agent and the tissue response to it—you still have a personality to deal with.' Psychiatrists have long realized that psychiatry contains more problems than those dealing with the physiology and pathology of isolated organs. But the field is still mainly in a descriptive state, as pointed out by Macfie Campbell and others. Of course, every effort is made to achieve a genetic-dynamic understanding of the cases.

It is here that psychoanalysis has a most important contribution to make; for a comprehensive genetic-dynamic understanding is for the psychoanalyst not merely a goal and ideal, but a realized actuality, the very basis of his work. The essence of psychiatry is that it works with psychological data. The approach is through the history, the behavior, and the utterances of the individual. The physical findings are integrated into the picture, reflect themselves in the psychology of the individual and are inseparably interrelated with it. The approach to these psychobiological problems is through an understanding of the individual's history, behavior, thoughts and utterances. The mainsprings of these however are unconscious. The dynamic unconscious is the contribution of psychoanalysis and the element which brings together and makes comprehensible the vast mass of descriptive data which clinical psychiatry accumulates.

Unfortunately the contributions of psychoanalysis, as is apparent from this volume, are misunderstood even by some of the foremost psychiatrists. One of the misunderstandings is that it is conceived of only as a technique of treatment through transference and not for what it is also, and more significantly, namely a specialized scientific technique of genetic dynamic observation and understanding. The transference is spoken of as a special, artificial relationship between patient and physician, and hence of no interest to the psychiatrist who is interested in the dynamics of the patient's reactions in real life. But in point of fact, the great value of the analysis of the transference is that it provides a sample of the patient's most typical life reactions, seen not through the history alone, but in reality, at the moment, to the physician, so that these can be studied directly, and not merely reconstructed theo-

retically. The psychoanalytic procedure is a technique of scientific, laboratory observation in the fullest sense of the words. The psychoanalyst establishes a standard situation and encourages the patient to express himself freely in words. This is found to result in a certain flow of content and in the development of intense conflicting feelings toward the psychoanalyst, which prove to be a reliving, in actuality, under the very eyes of the observer, of the genetic history of the emotional conflict which the patient had experienced early in life toward those close to him. This is a simple method in the standard scientific tradition, of isolating and directly observing under controlled conditions, a typical sample of the reactions to be studied (those to the physician). It is unfortunate that it should be misunderstood. This is probably due, among other reasons, to the normal universal resistance to unconscious material and to the long period of special study and practice which are necessary to master the technique. Recognition is growing however. There is an article by Rado, who was invited to speak on the undergraduate teaching of psychoanalysis, and some psychoanalytic observations and theories are summarized by Dr. Meyer with the recommendation that they be tested by the experience of psychiatrists. But then the same method must be employed. Otherwise some of the most patent observations will be missed.

The report is of special interest in that it records the points of view of outstanding American psychiatrists. These can not well be summarized in a brief review. Anyone interested in the personal approaches of any of these psychiatrists will learn a great deal about them from reading the article. A perusal of the entire report will convey an excellent idea of the main attitudes and trends in modern American psychiatry.

This review has considered chiefly the question of psychoanalysis as the point most interesting to readers of this journal. The following summary of recommendations by the Committee on Recommendations will serve as an indication of the temper and content of the report:

'The conference stands for the freest possible shaping of the program of undergraduate training in psychiatry, adapted to the conditions of the medical school.

'There should be no invidious comparisons of the simpler pro-

grams of certain less favored medical schools because there are many ways of reaching reasonable patterns of efficiency.

'It is considered a healthy sign that a variety of procedures should be cultivated and encouraged according to the local conditions and tendencies of emphasis of material and interests.

'The main hope is in the direction that accurate and understanding knowledge of the work of the different centers be exchanged, and that a stimulating urge to know each other and each other's work be cultivated.

'There is no tendency to stereotype either methods or ideology and concepts and terminology beyond a point of a demand of sufficient clearness of definition and reasonable accounting for the differences and departure from the converging tendencies today.

'The conference stands for a practical exchange of demonstrations of local patterns by continuation of the plan of visits to various centers.

'The goal is that of stimulating the student's sense for the personal reaction and problems of the patient in any medical or surgical or obstetrical case, not only in the obviously psychiatric or psychoneurotic patient. The training in work with psychoneuroses and psychiatric cases is to offer the student familiarity with the essential disorders and their hazards which he must be able to meet as intern, in accident and admission service and in the care of depressions and attempts at suicide, delirium, excitements, stupor and care pending commitment and emergencies, but also in the home and office care of patients not prepared to go to hospitals. The standard had best compare with what is expected of the intern or practitioner who has to assume responsibility without further postgraduate study, similar to what a physician not trained for surgery should know of surgery. He must be a dependable intermediary between patient, family, and specialist, and an adviser in milder types of disorders.'

LEON J. SAUL (CHICAGO)

THE FOLKLORE OF CAPITALISM. By Thurman W. Arnold. New Haven: Yale University Press, 1938. 400 pp.

This book is written by the man who recently threatened the American Medical Association with the anti-trust laws because he considered that the Association was obstructing efforts to provide more adequate medical service for certain groups. But the chief

interest of the book is by no means in this connection. It is a book which is of the most direct interest to psychoanalysts as well as to everyone who has any concern either with social psychology or with the problems of the particular society in which he lives. It is to be hoped that this book is symptomatic of an increasing application of the scientific method, particularly of the fundamentals of psychoanalytic observation, to the problems of social organization.

The main point of the book is the introduction of the concept of what the author calls 'the subconscious mind' in the study of social phenomena. His concept of this subconscious mind is not identical with the psychoanalytic unconscious, but it is close enough to it to make the book an unusual and very important contribution. In the opinion of the reviewer, it is the fact that the author does not take the next step and actually utilize psychoanalytic knowledge of man's unconscious mental life and the unconscious elements in his behavior that keeps the book from being a great work.

The central idea is that 'thinking men' do not consciously and deliberately choose a form of social organization or a system of government. Instead, these organizations develop 'subconsciously' out of practical needs, rituals and ideologies. It is therefore possible to distinguish between, on the one hand, practical needs and on the other, the ideologies, ceremonies and rituals which Arnold calls the folklore. He shows that one of the greatest difficulties in seeing social realities derives from the fact that the observer becomes involved in folklore. For example: America developed the folklore of 'private property' and of 'rugged individualism', and at least until 1937 maintained these concepts and endeavored to describe the existing order in these terms, whereas the things described were neither private nor property, nor personally owned. 'Wealth today consists in nothing any one individual can use. The standards of wealth are simply current expectations of how the individual stands with the rulers of industrial baronies coupled with a guess as to the strength of those principalities. . . . There are, of course, people in this country who still own independent private property but they are far down in the social scale. Such people live in states like Vermont.' 'Today furniture and automobiles are the nearest we come to private property, generally owned by any large group of our population' and with the automobile the owner is dependent upon large organizations for the

fuel and repairs. What we face in actuality are great business organizations but we think of them as individuals; yet folklore is an invariable part of any organization and must be examined and evaluated as such.

The discrepancies between folklore and practice may be great. For example, the creeds of the dictatorships are a most inadequate description of what they actually do. Folklore acts as a powerful brake upon social change. 'This reaction on the part of both economists and lawyers [to being shown the realities of the social scene] is natural and inevitable. It is part of the process by which newly observed facts become assimilated into an old religion. It may be compared to the impact of Darwin on the Church of England. It may also be compared to the reaction of the ethical philosopher at the beginning of the century toward psychoanalytical descriptions of "love" and "honesty". The churchman and the philosopher felt their ethical world crumbling, just as legal scholars today feel their jurisprudential world crumbling under the impact of an objective analysis.'

The analogy to the University of Paris is given. This medical supreme court of the Middle Ages once based medicine on principle and theory. Disease was due to devils and bad humors which had to be eliminated by exorcism and bleeding. When the Jesuits discovered that quinine cured malaria, they were medical heretics and anyone who used this empirical remedy was a Jesuit or a quack because obviously it did not fit into the medical theology of the University of Paris. Since that time, medicine, following other branches of science, has abandoned schools and theologies for the development of techniques and the observation of facts. Hence, schools of medical thought which dissipate their energies in attacking each other have practically disappeared. It is this point of view which the author wishes to introduce into sociology '. . . one which allows a place to the folklore necessary for social organization, but does not mislead us with respect to its function in society. It is the point of view of modern psychiatry without its classifications. This attitude has not attained the dignity of a formulated philosophy. It is one which the realistic politician has taken all along. The task of the philosopher is to make it respectable so that respectable people can use it.' Doctors are selected because of their technical skill not because of their ability to make speeches. In tackling the cancer problem, the scientist does not passionately

take sides, he endeavors to learn something about the nature of the malady.

Analogous to mechanisms in the psychology of the individual, when there exists a practical need (frank handling of which is not permitted by the folklore of the time) then *sub rosa* organizations grow up to fill it. For example, during prohibition the ideals of law enforcement and puritanism were carried out by the government but this interfered hardly at all with the actual dispensing of liquor by the bootleggers. It merely meant that the liquor was dispensed by nonrespectable people instead of by respectable bartenders. So, too, Theodore Roosevelt wielded his big stick and gesticulated against monopoly but the anti-trust laws in no way hindered the development of great trusts that simply used different legal techniques. Another example is the political machine that develops to take care of practical needs neglected by respectable people. 'In such a situation the public shuts its eyes to violations of its ethics with the same unconscious response which makes the individual ignore the so-called "lower side" of his own nature in public.'

Every analyst will probably think immediately of another example: the attitude of official medicine to psychiatry and psychoanalysis. Faced with the great need of the people for help in their neurotic sufferings, the medical men became angry with the neurotics for not having the kind of disorder which fitted the medical folklore. Hence there came to exist every type of religious and medical quack to fill the needs of the neurotic sufferers. Gradually as official medicine becomes a little freer of its mechanistic theology and a little more frank in facing the problems of the neuroses, more respectable medically trained people are going into this field. Eventually it is to be expected that the theological attacks upon psychoanalytic doctrine as heresy and the arguments between the schools of approach to mental problems will give way before the search for knowledge and techniques to meet the practical needs of the neurotic sufferers.

It seems to the reviewer that the basic problem of man's hostilities can be formulated in similar terms. If respectable leaders do not recognize man's latent destructive drives, these are utilized *sub rosa* by groups that sometimes come into power, and by utilizing for their own interests man's impulses to violence, threaten civilization. Only when the respectable leaders and the

people frankly recognize these destructive drives in men and deal with them openly, will man's destructiveness be less of a threat to man's very existence.

The reviewer finds it impossible to give a really adequate summary of the important points of this book which is written in a most condensed and witty style. Merely to mention some of the other topics, it is shown how learning and concentration upon abstract ideals hinders observation of social realities and the solution of practical problems; how government is considered to be a spiritual organization whose function it is to preach while the temporal government is in the hands of the great business organizations. 'The attitude of the conservatives toward government in business was the same as toward a minister of the church who deserted his pulpit to buy a seat on the stock exchange.' The dangers of definitions and polar words are discussed and an amusing example is given of how one can rationalize his behavior by the use of such polar words as—efficiency, inefficiency; rugged individualism, paternalism; communism, fascism, etc. There is a discussion of the effect of the anti-trust laws in encouraging large combinations; and corporate reorganization is presented as a ritual and rationalization. There is also a penetrating and witty delineation of the methods of thinking which blind the population to taxation by private organizations to which they are constantly subjected in actuality, and at the same time lead them to an attitude which obstructs making government taxes pleasant and effective. The author is cautious about predictions, for '. . . if we look backward over history, we can see how impossible it is to stand in one age and predict the social philosophy of the next. On what basis could anyone in the Roman Empire predict the peculiar philosophy of feudalism? How could the wisest man in the twilight of the Middle Ages have predicted the philosophy which glorified the trader and made human greed the fountain of justice and morals? How would it have been possible to have foretold the development of the great modern corporate organization out of a philosophy of rugged individualism? Even Adam Smith, who described his own time so accurately, stated with complete conviction that the development of the great corporation was economically impossible because men would not work for corporations as they worked for themselves. Unless the profit motive is to disappear, he argued, such organizations will be absolutely impossible,

because of the underlying factors which make up "human nature".'

The book closes with a chapter on principles of 'political dynamics' which the author takes as a name for this type of approach to sociological problems. This chapter contains some of the author's generalizations from his empirical observations. Each one is illustrated by concrete examples.

It is to be hoped that this book will lead the way to other works of the same kind. Followed to its logical conclusions it would come to be an approach to social problems which would avoid the pitfall of practically all other approaches—a neglect of the fact that sociology rests basically upon the behavior of human beings, and that a rational approach to social problems must include an understanding of individual psychology. The book can not be too strongly recommended. It is fundamental for the study of socio-psychological problems.

LEON J. SAUL (CHICAGO)

DIE PSYCHIATRIE IM DIENSTE DER WEHRMACHT (Psychiatry in the Service of Military Defense). By Adolf Heidenhain. Leipzig: Georg Thieme Verlag, 1938. 53 pp.

This work purports to be a contribution to military psychiatry. The approach is descriptive and statistical: there is much citation of earlier works on the subject, and little or no original observation is presented. One learns, for example, that the psychopath presents the numerically greatest military-psychiatric problem, that the rural population offers better material for military personnel than the urban population does, that homesickness presents no difficulties for the German soldier (though it may well do so for the soldier of other nations, particularly the French), and similar odds and ends. All of this is very little helpful to the general psychiatrist and of no use whatever to the psychoanalytic reader.

The interesting feature of the work for the present reviewer, as it would probably be for the average non-German reader, is the glimpse that it gives into psychiatry under the Third Reich. The author, now dead, while not stridently National Socialist, gives evidence of having been acquiescent in the present-day political trend and approaches his subject from a definitely totalitarian viewpoint: his concern is with the good of the army; the welfare or, indeed, the problems of the individual soldier are of distinctly secondary concern, if any. While any exhaustive psy-

chiatry must bear in mind the welfare of the group as a whole, the history of psychiatry makes it very clear that all of the really valuable contributions to the subject have been based upon study of the individual, as the development of psychoanalysis so richly testifies. One would expect, therefore, that the Third Reich, whose doctrine it is that the State is all and the Individual of no account, would make no signal contributions to psychiatry. The present work fulfils this expectation completely.

There is a lengthy bibliography, entirely innocent of any psychoanalytic title. The names of the authors cited seem mainly 'Aryan', though a few appear to bear the 'non-Aryan' taint.

WILLIAM V. SILVERBERG (NEW YORK)

NEUROLOGY. By Roy R. Grinker. Second Edition. Springfield, Illinois: Charles C. Thomas, 1937. 968 pp.

For the psychoanalyst there is no better general compendium of information about modern neurology than this book. Particularly useful and stimulating will he find the chapters on the vegetative nervous system, and on the anatomy and physiology of the blood supply of the central nervous system.

The book is written from a purely organic point of view, and is concerned solely with organic disease of the nervous system. As such, it is a useful reference book both for careful factual data, and as a guide to the modern literature on any particular topic.

It is pleasant to note that many of the stylistic imperfections of the first edition have been corrected in this second edition.

L. S. K.

GLANDS AND EFFICIENT BEHAVIOR. By Florence Mateer. New York: D. Appleton-Century Co., 1935. 237 pp.

In the introduction to this book (page XXII) one learns that 'complexes are bound to result' from spontaneous insulin shocks, from disturbances in water metabolism, and from disturbances in iodine and bromide metabolisms.

On page ten we discover that 'inefficiency is the lack of efficiency'. Elsewhere tics are ascribed to low calcium, and marked improvements are reported in certain cases of Mongolian idiocy by 'gland feeding'.

Essentially the book rests its case, insofar as it has one, on

fragmentary reports of experiences with patients who, in addition to a neurosis or some type of mental deficiency, suffered at the same time from some metabolic or endocrinologic disturbance. The relief of the accompanying chemical or metabolic disturbance naturally influenced in varying degrees the neurosis or the deficiency. No proof of causal relationships is presented.

The book is scientifically immature, confused, and valueless.

L. S. K.

DIE PSYCHISCHE IMPOTENZ DES MANNES. (Psychic Impotence in the Male.) By Edmund Bergler, M.D. Bern: Verlag Hans Huber, 1937. 147 pp.

After the publication of his book on frigidity (with E. Hitschmann, 1936) Bergler has now written a new book about the clinical picture, psychoanalytic theory and treatment of impotence. A general part about the development of masculine sexuality and the definition, symptomatology and degree of impotence is followed by a detailed description of the different forms of impotence which are systematically described according to psychoanalytic conception of their psychogenetic structure.

Impotence with phallic mechanisms is represented in the hysterical neuroses and may occur in many different forms: complete sexual abstinence with masturbatory equivalents; nocturnal emissions; erective impotence and the impotence of the passive feminine unconsciously homosexual man. To this same group of hysterical impotence with phallic mechanisms belong different forms of 'orgastic impotence' (meaning a physically normal act but without normal satisfaction). The well known symptoms resulting from separation of tender and strictly sexual components often resulting in unreliable potency belongs in the group of hysterical disturbances. The clinical picture of impotence is complicated by numerous specific hysterical mechanisms apparent in different syndromes: for instance fear before marriage; fear of defloration or of impregnation; compulsive faithfulness; impotence at the beginning of every new sexual relation. Some forms of partial impotence may be overcome by certain rites or conditions: the love object must be an elderly woman, must allow or forbid sexuality with certain words and so on.

Impotence with anal mechanisms includes the impotence of the compulsive neurotic, of the chronic hypochondriac and of

certain masochists. To the same form of impotence belongs 'psychogenic aspermia', a term used by the author as a name for a special kind of ejaculatory impotence.

Impotence with oral mechanisms includes cases with pseudo-debility, certain types of aspermia, ejaculatio præcox and priapism.

The book illustrated by a tremendous amount of concise case material is a highly valuable contribution to psychoanalysis.

MARTIN GROTJAHN (CHICAGO)

PREDICTION AND PREVENTION OF READING DIFFICULTIES. By Margaret A. Stanger and Ellen K. Donohue. New York: Oxford University Press, 1937. 191 pp.

This book makes perplexing reading for the analyst who has had occasion to study difficulties of language in children or adults: it shows how the authors, following the theory suggested by Dr. S. T. Orton, have developed a method of enabling children to overcome completely difficulties in learning to read, and even the frequently accompanying symptom, stuttering. To accept the authors' belief in the validity of the theory as witnessed by their results would make the psychoanalytic approach to these problems superfluous.

Stanger and Donohue use as the theoretical basis of their work the concept of cerebral dominance. Quoting from Orton they state, '. . . one side of the brain is all important in the language process and the other side either useless or unused. . . . a very small area of destruction in an appropriate area of the controlling or dominant hemisphere of the brain will give rise to extensive loss in speech or reading while an equal area of destruction in exactly the same part of the non-dominant or subjugate hemisphere will be followed by no language disorder whatsoever, and indeed will often give no recognizable symptoms. The concentration of the whole control of speech, reading and writing in one half of the brain bears an intimate relation to the development of unilateral manual skill in the individual.' Heredity seems to be the factor which determines which side will dominate. Consequently where the hereditary pattern is confused there is a corresponding confusion—lack of lateral dominance—and therefore retarded, often impeded development of the language functions.

Realizing the discouragement and the frequent emotional problems which develop in otherwise intelligent children who find

themselves unable to read while their classmates forge ahead, the authors set out to find a method of selecting those children before their difficulties become a stumbling block. This is accomplished through a battery of tests which determine handedness (in spite of any training which might have taken place to counteract left-handedness), eyedness, footedness, and visual-imagery. These last tests are especially ingenious since they show whether or not there is a tendency toward reversal or mirror-writing (reading *saw* for was, *ton* for not) even before the children can read.

As frequently as not, in spite of the parents' assertion that their child is right-handed, the tests will show a predominantly left-sided individual. Evidences of motor confusion, poor handwriting if the child has already commenced to write, or awkwardness in play, will disappear if the child is permitted and encouraged to use his left hand.

Once the selection has been made, children evidencing confusion are given instruction in reading and writing by a specially devised method. In contradistinction to the usual predominantly visual-auditory method, Stanger and Donohue reinforce this through the speech organs by repetition of the sound of the letter and its name and through the use of the hand and arm muscles when letters are traced.

The practical aspects of this book are more convincing than the theory upon which it is based. The children who are thus trained are able to read and write; many of those who also stuttered are able to speak fluently. Certainly there can be no question that the method used is successful. But is the method really as much an outcome of the theory above mentioned as the authors appear to believe?

The authors do not mention, and are evidently unaware of the fact that similar results have for some time been successfully but somewhat differently achieved by Dr. Grace M. Fernald [1] in connection with the University of California at Los Angeles. Dr. Fernald has had excellent results by permitting the child to trace whole words at a time, a much simpler and quicker method than that of Stanger and Donohue, which makes the child go through the tedious process of learning each letter individually. Fernald in

[1] Fernald, Grace M.: *On Certain Language Disabilities—Their Nature and Treatment.* Mental Measurement Monographs. Baltimore: The Williams and Wilkins Co., 1936.

her criticism of Orton's theory points out that many of her most difficult cases were those of individuals who were right-handed and right-eyed, or left-handed and left-eyed, in other words, *with* lateral dominance. Moreover she has had great success with her method with cases which Donohue and Stanger would consider as still showing confusion. She says: 'The eye and hand dominance is not changed as a result of the remedial work: that is, the subject with unmatched eye and hand dominance learns to read and is able to read in an entirely normal manner with eye and hand dominance still opposite.'

Fernald points out that Orton fails to explain why dominance is not established by certain individuals. She believes that individuals differ in brain structure and brain specialization and that in some there is an absence of visual imagery during the initial learning process. 'Most cases of reading disability are due to the blocking of the learning process by the use of limited uniform methods of teaching', by which she means, the stressing of the visual-auditory, the omission of the kinesthetic method, and the suppression of motor adjustment—the lip, throat, and hand movements. In her experience, visual imagery is established after the child has had the opportunity to learn by means of the kinesthetic method.

Fernald's viewpoint would thus explain Stanger and Donohue's success. Their procedure also depends largely on tracing, i.e., learning kinesthetically by use of the hand and arm muscles. Those cases in which progress seemed to be the result of encouragement to use the left hand instead of the right might be explained by the fact that such training served to counteract the attitude of the environment of those particular individuals. Those whose environments condemned the use of the left hand as unmannerly, disgraceful, or because it might lead to awkwardness or inconvenience later in life, would of course be inhibited in their free development. Fernald's findings would appear to show conclusively that there is no reason why children who show a tendency to be bilateral or ambidextrous should necessarily be inclined to have difficulties with language.

Psychoanalysis may be able to throw some light on the causative factor in the lack of visual imagery. Fernald seems to be of the opinion that in most cases there is a physical basis for this, although she admits that 'emotional instability may be the cause of reading

disability' in some cases. It is quite conceivable that the primal scene might cause a repression which would later become particularly evident when the child is confronted with a situation in which the use of his eyes plays such an important rôle. It is likewise plausible that through the transference established toward the teacher, and the placing of emphasis on the kinesthetic rather than the visual method of learning, that the emotional block to learning is overcome.

Stanger and Donohue's main contribution to the understanding of the child lies in the method they have devised for the recognition of what they have named 'confusion of dominance', but could perhaps be better named, poor motor coördination and lack of visual imagery. The most important factor is the recognition of such difficulties and to take measures to overcome them. Which of those measures will be indicated in a particular case—the new method of teaching or psychoanalysis—will depend largely on the diagnosis of the general emotional stability of the individual child.

MARJORIE R. LEONARD (LOS ANGELES)

SOCIAL PSYCHOLOGY. By Daniel Katz and Richard L. Schanck. New York: John Wiley and Sons, Inc., 1938. 700 pp.

This book is by two psychologists. It represents not an emancipation, but at least a distinct advance over many of the psychological and sociological college text books, from academic thinking to an attempt to grasp social realities. The authors see the need for this advance, for the necessity that psychology and sociology deal with actual vital issues in the world. They see that sociology deals with human beings and must be sterile unless it takes into account human motivation.

Their plan of approach is to present the social scene from three points of view: that of the man on the street, that of the clinician, and that of the social engineer. In addition, there is a section entitled 'The Scientific Basis of Social Progress'. The book is at its best in describing the world of the man on the street and the world of the social engineer. In these sections the authors deal with social realities. Interesting illustrations are given of fads and *mores,* and of the J-curve hypothesis. This is to the effect that a great variety of sociological studies show a distribution in which the vast majority of cases build up the long arm of the J and there is a sudden dropping off of the minority in the form of a J-curve

graph. This curve is obtained by plotting the results of such diverse studies as the attitude of Methodists regarding consideration of the bishop in selecting the local preacher, promptness of registering to insure continued employment, length of motorists' over-parking, and the belief of Catholic men in the deity.

The last section of the book presents a good summary of the local, national and international scene, including the development of social classes. The second section, however, goes scientific. It is academic and unconvincing as compared with the other sections. The same holds true for part three on the social world of the clinician. This seems to be due chiefly to the fact that the authors feel the need to convince the reader, and possibly themselves, that there is really a body of academic and clinical psychological knowledge which has been applied significantly to social problems. At the end of section two they say, 'physiological mechanisms of human conduct have been described and the psychology of human motivation has been explained. . . . equipped with an understanding of the mechanisms of behavior and the mainsprings of action, we shall return . . . to the practical realm of social events'. This chapter of course does not equip the reader with an understanding of 'mainsprings of human action'. The authors do not appreciate what the attitude of the clinician to social problems really is. But it is to their credit that they attempt to utilize this knowledge in their presentation.

They give Freud credit for stressing the importance of motives in human behavior but nowhere is psychoanalysis mentioned and Freud's works are omitted from the bibliographies, even from those chapters which quote from and discuss them. It is unfortunate that in a book which is basically sincere, the authors should feel called upon to follow tradition in mouthing criticisms of certain elements of psychoanalysis which they completely misrepresent, such as, for example, sublimation. Also, they give to the analytic concepts a peculiar quirk and a misrepresentation in treating them as dialectical in a strictly Hegelian sense. They say, for example, 'the pleasure principle thus negates itself', in describing the growth of the ego.

It would be interesting to know why they utilize the freudian description of the development of the ego, the concepts of the reality and pleasure principles, and so on, without including any references to the works upon which these are based and often with-

out giving credit to psychoanalysis. Is it to protect the students? Or is it to protect themselves from criticism? The authors do not mind the broad freudian generalizations such as the reality and pleasure principles, but they shy off from the real clinical facts of aggression, sexuality, masturbation, guilt, the father conflict. In other words, the real mainsprings of action are presented in extremely diluted form, if at all. And the reader is protected from them by omitting all references to the original freudian writings, with the single exception, Totem and Taboo. There is a quotation from The Future of An Illusion, which deals with the suppression of one class by another, but no reference is made to the main points of the book and it is stated that Freud is interested only in mental hygiene and in the mind of the individual. The quotation is utilized not for psychological insight but as an introduction to a sketch of the class struggle. However, with all these misrepresentations, misunderstandings and emasculation of psychoanalytic knowledge, one must not forget that after all psychoanalysis is a field of knowledge which only the rare individual can grasp without thorough personal analysis and long study. Indeed it is a question whether it can ever be really appreciated through academic study alone without going through the fires of clinical practice, which perhaps alone reveal first hand the nature of man's emotional life. It is to be expected that significant contributions will result when sociologists approach certain of these sociological problems equipped with a thorough psychoanalytic understanding.

At any rate, although the book still clings to experiment as something of a fetish, it shows a definite emergence of interest from academic to vital problems—analogous to the advance from the stage of philosophizing and magical experimenting about anatomy and astronomy, to that of dissection of cadavers and charting of the stars—to direct observation of the central phenomena to be studied.

LEON J. SAUL (CHICAGO)

MENTAL HEALTH THROUGH EDUCATION. By W. Carson Ryan. New York: The Commonwealth Fund, 1938. 304 pp.

To trace where an idea came from, how far it has gone, what happened to it on its way, is always tantalizing. Few interests ordinarily lead to wider speculation, less proof. The more general

the idea and the more social the areas to which it has been applied, the more maze-like the route. Yet W. Carson Ryan has been able to be specific, time and again, about the actual application in education of the none too tangible concepts of mental health. What is more, he has even been specific as to what modern education is about.

Mental Health Through Education 'seeks to answer the question: How does educational practise today, at every level and for every type of education, square with what is known of mental hygiene, and what further advances can be made?' The book speedily, selectively does just that. Dr. Ryan, with the aid of The Commonwealth Fund, has surveyed public and private education, nursery school through college and into teacher education. He chose to omit private college preparatory, and special schools. He appears familiar with the relevant literature. His range is wide enough to include school architecture, teacher selection, methods, and the tragedy of tragedies—bored children.

Whenever anything of value was spotted it is described with evaluation. The investigator found excellent work being done by the White-Williams visiting teachers in Philadelphia; by Lois Meredith French in the New Jersey State Normal School at Newark; by some of the private progressive schools, by the mental hygiene-minded nursery schools and other groups. Little time is wasted in sighing about work untouched by a mental health approach.

Certain present day educational standards suggest direct influence of mental hygiene attitudes to Dr. Ryan. An emphasis on an individual approach to children in the classroom, a knowledge of childrens' family and community life, a reduction in competitive activities, an elimination of purposeless rote learning, and a tendency to smaller classes are among the evidences he sought. In general, these and other standards were observed so much less often, as children advanced beyond early elementary ages that almost none was visible in most high schools and colleges. He found hierarchies heavy, custom powerful, physical health neglected, schools isolated. But Dr. Ryan leaves horror stories for others. The last part of his problem 'and what advances can be made' intrigues him far more than conspicuous failures.

Psychiatric contributions, through clinical services and staff

appointments, are scrutinized especially as they may have influenced the administrative and teaching staffs. And they have been influential down to the level of classroom procedure. Dr. Ryan suggests, however, that not only are psychiatrists expensive, but in general their training leads to less understanding of educational problems and possible solutions than is true of such workers as visiting teachers. Dr. Ryan is dubious as to how many psychologists are imbued with a mental health attitude—which he defines. To be of most use he believes the psychiatrist, the visiting teacher, the parent educator, and other leaders should be inherent in the school structure, not luxury appendages.

It is the author's not the reader's privilege to suggest the scope of any one book. However, a reader may feel regret: regret, for instance, that Mental Hygiene Through Education does not attempt to evaluate the standards of either the strictly mental hygiene nor those of the most advanced educational fields. In education the new, the experimental, may be so refreshingly welcome as to seem of value. And it is—compared to the worst of the old. But, for instance, the educator does not obliterate competition, assuming that it is possible, by having no report cards, varsity teams, and prizes. Nor does he automatically assist a child to realistic adaptation to his total milieu, now or later, by less rote learning in a small class. Dr. Ryan himself certainly cannot be charged with depending on method. But he could illuminate the efforts of modern education by a more penetrating discussion of his views of a school's function in the social scene. He owes the reader his analysis of the basic purpose of school life if his summary of standards is to be convincing.

Psychiatrists not previously in close touch with ordinary schools may hesitate, after reading this survey, to suggest that 'the teacher give more attention to this child' or 'offer him a richer curriculum'. Dr. Ryan would endorse firmly such suggestions, but might think them futile in the face of the usual teacher's inadequate training, attitudes, and working conditions. In his final chapter he outlines how millions of children could have more attention, richer curriculum (especially in the arts) if attitudes were taken out of words, put into procedure. He only suggests that what is being done well in a small way be equally well done in a large way!

With vision yet not visionary, Mental Health Through Educa-

tion damns by implication most schools to which most children are committed and indicates possible ways to prevent and alleviate a vast number of difficulties now listed under 'school maladjustment'.

ELIZABETH HEALY ROSS (PHILADELPHIA)

THEORY AND ART OF MYSTICISM. By Radahakmal Mukerjee, M.A., Ph.D. New York and London: Longmans, Green & Co., 1937. 308 pp.

Of its kind, this is an excellent book: a comprehensive and authoritative discussion not alone of mysticism, which is defined in the Preface as 'the art of inner adjustment by which man approaches the universe as a whole, instead of its particular parts', but of religion in general. It is also a defense; for, according to the author, the highest religion, which 'has kept alive in society a faith in certain ultimate values that has also guaranteed social development towards higher levels', is today labeled mysticism and 'shares with magic, myth, and miracle a common disrepute'. But in spite of its undoubted merits within its field, the psychoanalytically oriented reader will be unable to regard the book otherwise than as Hamlet without the Prince of Denmark, for despite its inclusions he will be even more aware of its omissions, even though the latter are of a nature wholly to be expected.

There are three references to Freud or to psychoanalysis; in these the author shows himself rather less well-informed than is otherwise his wont. 'The conviction has gained ground that mysticism, which is the soul of living religion, implies aberration rather than normal growth of personality. . . . Thus, from Ribot to Freud and Leuba, what is for the most part religious aberration or mania has been examined, though not without sympathy, and the result has been that religion itself is discredited or regarded as illusory.' Again, voicing anew a well-worn misapprehension: 'The rôle of religion is underestimated further by a group of thinkers of the Psycho-Analytic school, who regard religion as a purely subjective thing, an outcome of an infantile projection of consciousness, surviving simply because it meets certain elementary tendencies of human nature [as assuredly it does: 'The Lord is my Shepherd; I shall not want'—'O Death, where is thy sting? O Grave, where is thy victory?' etc., etc.]. Such an analysis, which has sometimes been carried to extremes, is defective because it derives its materials mostly, if not solely, from morbid and

pathological cases. Thus a theory of religion, derived from abnormal experiences, or emphasizing certain pathological tendencies which may be present in the apparently normal mind, is hardly scientific.' And once again: 'This fact of an ideal kinship [with the totem] is, indeed, far more important than the impulse of fear which the totem may excite. Freud overemphasizes the fact of fear in order to subsume totemism under his generalization of the Oedipus Complex.'

H. A. B. (NEW YORK)

CHARACTER, GROWTH, EDUCATION. By Fritz Künkel, M.D. Translated by Barbara Keppel-Compton and Basil Druitt. Philadelphia: J. B. Lippincott Company, 1938. 348 pp.

This is another one of those books presumably intended to popularize mental hygiene and child guidance but limited in any such purpose to the totally uncritical reader. Apparently intended to deal with the problems of social consciousness and the integration of the individual with the group, the book actually contains only vague smatterings of Adlerian and Jungian teachings, intermingled with the author's peculiar formulations of his own school of 'We-ness' and 'We-Psychology'. The absence of thought content in the book is compensated for by a special terminology, of which the following examples, taken from chapter headings and not defined in the text, will suffice: The Collapse of the We; Upward Growth (Circulus Vitiosus and Circulus Virtuosus); Interests (Deflected Finalization and Predisposition); Crisis of the Illusory Ripening-We; Crisis of Class-Struggle Ego-Construction.

MILTON H. ERICKSON (ELOISE, MICHIGAN)

DER ZYKLUS DER FRAU—REFORM DES EHELEBENS (The Cycle of the Female—Reform of Married Life). By Dr. Jules Samuels. The Hague: G. Naeff, 1938. 175 pp.

It is not possible for a psychoanalyst to judge the scientific value of this book and further research is needed to investigate the basis of the author's methods, findings and conclusions. He has invented a simple apparatus which he calls the 'zykloskop' with which it is possible to make spectroscopic examinations of the blood in the skin vessels between the index finger and thumb. In the spectrum the reduction-time of the oxyhemoglobins to methemoglobin can be

exactly determined. This time is supposed to indicate the hormone content of the blood. The results are very surprising and unbelievable in their consequences: ovulation time may be determined to the hour; very often two and three ovulations can be observed during one menstrual cycle; pregnancy can be diagnosed a few days after conception; rational timing of endocrine therapy is possible and a new method is given to judge the success of endocrine treatment. It is possible to give the exact time when women are sterile and to gain exact knowledge about the state, kind and pathology of the female cycle. The author calls the seconds of the reduction time the notes from which everybody is able to read the music of the endocrine concert. Among the many questions which are stimulated by the reading of the book arises the problem of the constancy of the reduction time of the male and his 'cycle'.

If methods and results of Samuels' research should be confirmed, psychoanalysis would get a new basis for a promising means of coöperation with the physiologist.

MARTIN GROTJAHN (CHICAGO)

CURRENT PSYCHOANALYTIC LITERATURE

The International Journal of Psycho-Analysis. Vol. XIX, Part 4, October 1938.

SIGMUND FREUD:	Constructions in Analysis.
KARL LANDAUER:	Affects, Passions and Temperament.
OTTO FENICHEL:	Ego-Disturbances and Their Treatment.
PAUL HEILBRONNER:	Some Remarks on the Treatment of the Sexes in Palæolithic Art.
ERNEST JONES:	A Psycho-Analytical Note on Palæolithic Art.
LEON J. SAUL:	Psychogenic Factors in the Etiology of the Common Cold and Related Symptoms.
FRITZ WITTELS:	The Position of the Psychopath in the Psychoanalytic System.

The Psychoanalytic Review. Vol. XXVI, Number 1, January 1939.

PHILIP R. LEHRMAN:	Psychopathological Aspects of Emotional Divorce.
EDMUND BERGLER:	On the Psychoanalysis of the Ability to Wait and of Impatience.
RALPH M. CROWLEY:	Psychoanalytic Literature on Drug Addiction and Alcoholism.

Revue Française de Psychanalyse. Vol. X, Number 3, 1938.

GARMA:	Essai de Psychanalyse d'Arthur Rimbaud (*An Attempt to Psychoanalyze Arthur Rimbaud*).
EMILIO SERVADIO:	Le Cerf-Volant, le Feu et la Foudre. Contribution à l'Etude Psychanalytique des Symboles et des Mythes (*The Kite, Fire, and the Lightning-Bolt. A Contribution to the Psychoanalytic Study of Symbols and Myths*).
EDOUARD PICHON:	La Personne et la Personnalité Vues à la Lumière de la Pensée Idiomatique Française (*Person and Personality Seen in the Light of French Idiomatic Thought*).
EDOUARD PICHON:	Evolution divergente de la Genitalité et de la Sexualité dans la Civilisation Occidentale (*The Divergent Evolution of Genitality and Sexuality in Western Civilization*).
R. DE SAUSSURE:	Le Miracle Greg. Etude Psychanalytique sur la Civilisation Hellénique. Fin. (*The Greek Miracle. Psychoanalytic Study of Hellenic Civilization. End.*).
RENÉ LAFORGUE:	Le Facteur Thérapeutique en Psychanalyse (*The Therapeutic Factor in Psychoanalysis*).

Psychiatry. Vol. I, Number 4, November 1938.

JOSEPH CHASSELL:	Family Constellation in the Etiology of Essential Alcoholism.
DAVID M. LEVY:	Maternal Overprotection.

Bulletin of the Menninger Clinic. Vol. II, Number 6, November 1938.

BERNARD A. KAMM: Resistance Problems.
KARL A. MENNINGER: The Cinderella of Medicine.

Vol. III, Number 1, January 1939.

KARL A. MENNINGER: The Psychological Factor in Disease.
EUGENE EISNER: Phantasy in Mal-Adjusted Children as Observed in Three Cases at the Southard School.

The American Journal of Orthopsychiatry. Vol. IX, Number 1, January 1939.

GREGORY ZILBOORG: Overestimation of Psychopathology.
BURRILL FREEDMAN: Psycho-Social Repression and Social-Rationalization.
DAVID M. LEVY: Sibling Rivalry Studies in Children of Primitive Groups.

British Journal of Medical Psychology. Vol. XVII, Parts 3 and 4, 1938.

I. LATIF: Some Aetiological Factors in the Pathology of Stammering.

Journal of Nervous and Mental Disease. Vol. LXXXIX, Number 1, January 1939.

BEATRICE POSTLE: Pattern Features and Constitutional Susceptibility.

Vol. LXXXIX, Number 2, February 1939.

P. SCHILDER: Notes on the Psychology of Metrazol Treatment of Schizophrenia.

Social Forces. Vol. XVII, Number 1, October 1938.

JOHN DOLLARD: Hostility and Fear in Social Life.

Character and Personality. Vol. VII, Number 2, December 1938.

O. H. MOWRER: Some Research Implications of the Frustration Concept as Related to Social and Educational Problems.

Zeitschrift für Psychoanalyse (Tokyo, Japan). Vol. VII, Number 1-2, January-February 1939.

KENJI OHTSKI: Geldpsychologie aus analytischem Gesichtspunkt (*Psychology of Money from an Analytic Viewpoint*).
EIITI NOBUSIMA: Geld und Frauenpsychologie (*Money and Feminine Psychology*).
KENJI OHTSKI: Über Armenpsychologie (*On the Psychology of Poverty*).

Scientia (Milan, Italy). Vol. LXIII, Number 4, 1938.

EDMUND BERGLER: Über den gegenwärtigen Stand der psychoanalytischen Wissenschaft (*The Present State of Psychoanalysis as a Science*).

NOTES

THE AMERICAN PSYCHOANALYTIC ASSOCIATION will hold its regular spring meetings at the Palmer House, Chicago, Illinois, between May 8 and 12, 1939. These meetings will run concurrently with those of the American Psychiatric Association. A hall will be set apart for the use of the American Psychoanalytic Association. The exact duration of the meetings will be announced later, and will depend upon the amount of work that has to be covered in the business sessions, and on the number of papers accepted for presentation. Out of the topics suggested by the papers accepted, sessions will then be organized so as to have as much unity and cohesion as possible.

The annual spring meetings of the American Psychiatric Association will also be held at the Palmer House, Chicago, Illinois, from May 8 through May 12, 1939. As in previous years, there will be two special sessions, which will be known as the Conjoint Sessions on Psychoanalysis. Of these, the first is a meeting of the American Psychiatric Association as a whole with the Section on Psychoanalysis, in which the American Psychoanalytic Association takes no part as an organization. Customarily, this meeting takes place on Wednesday morning, and all arrangements for this session are entirely in the hands of a special committee of the Psychoanalytic Section of the American Psychiatric Association. If this year's program follows past customs, a second conjoint session will be held on the afternoon of the same day as the above. This second meeting is a joint session of the American Psychoanalytic Association with the Psychoanalytic Section of the American Psychiatric Association.

THE NEW YORK PSYCHOANALYTIC INSTITUTE. The Professional School of the Institute announces through the Educational Committee the following courses to be given in the winter and spring of 1939: *Special Psychopathology of the Neuroses and Psychoses—Part II,* lectures to be given by Dr. Sandor Rado. This course is open to members of the Institute, students in training (required course) and extension students on special application. Mondays, beginning February 20, 1939, from 8 to 9 P.M. and continuing for six successive Mondays with the omission of February 27 and March 27. A course of *Eight Clinical Conferences,* to be given by Dr. Rado. This course is open to members of the Institute and senior students in training (required course). Mondays, beginning February 20, 1939, from 9 to 11 P.M., and continuing for eight successive Mondays. A course of eight seminars entitled *Practical Application of the Rorschach Test,* to be given by Dr. Emil Oberholzer. This course is open to members of the Institute, students in training (optional course) and extension students on special application. Thursdays, beginning January 19, 1939, at 8:30 P.M., and continuing for eight successive Thursdays. A discussion

group of eight sessions on *The Psychoanalytic Approach to the Clinical Problems of Infancy and Early Childhood.* This group will be led by Dr. David M. Levy. The course is open to members of the Institute, students in training (optional course) and extension students on special application. Thursdays, beginning February 2, 1939, at 8:30 P.M., and continuing for eight successive Thursdays. A course of *Eight Clinical Conferences,* to be given by Dr. Sandor Lorand. This course is open to members of the Institute and senior students in training (required course). Mondays, beginning February 20, 1939, from 9 to 11 P.M., and continuing for eight successive Mondays.

The Extension School of the New York Psychoanalytic Institute announces a course of eleven seminars for physicians entitled *Psychoanalytic Approach to Practical Problems of General Medicine.* The general leader will be Dr. Clarence P. Oberndorf. There will also be a co-leader, chosen for his acquaintance with the psychological problems of the special field, namely: *1. Relation of Psychoanalysis to General Medicine,* Dr. Clarence P. Oberndorf; *2. Gastro-Intestinal Disorders,* Dr. George E. Daniels; *3. Cardio-Vascular System,* Dr. H. Flanders Dunbar; *4. Respiratory Disorders—Nose, Throat, Chest,* Dr. Carl Binger; *5. Gynecological Problems,* Dr. Max D. Mayer; *6. Genital-Urinary Problems,* Dr. Sandor Lorand; *7. The Eye and the Ear,* Dr. Philip R. Lehrman; *8. Skin Diseases,* Dr. Bela Mittelmann; *9. Psychological Problems of Childhood,* Dr. I. T. Broadwin; *10. General Psychodynamic Aspect of the Psychoses,* Dr. Leland E. Hinsie; *11. General Recapitulation,* Dr. Clarence P. Oberndorf.

This course is open only to those who have taken the Introductory Course in Psychoanalysis offered by the New York Psychoanalytic Institute, or its equivalent. The seminars will commence on Wednesday, February 1, 1939, at 8:30 P.M., and will be given for eleven successive Wednesdays, with the omission of February 22.

THE LONDON INSTITUTE OF PSYCHOANALYSIS has issued a report for the year ending June 30, 1938. The directors of the Institute are Ernest Jones, M.D.; Edward Glover, M.D.; Sylvia Payne; David Matthew; Marjorie Brierley; John Rickman, M.D.; and Ella Freeman Sharpe. The Report of the Director of Scientific Research is a statistical record of the work done at the Clinic. The Training Committee reports that on June 30, 1937, there were twenty-three on the active training list. The report contains in addition an account of Public Activities, the Business Secretary's Report and the Librarian's Report. During the year three books were published by the Institute and the Hogarth Press: The Ego and Mechanisms of Defense, by Anna Freud; Dream Analysis, by Ella Freeman Sharpe, and Clinical Aspects of Psycho-Analysis, by René Laforgue.